June 16, 2023

Kristen Jordan
Michigan Department of Health and Human Services
333 S. Grand Ave
Lansing, MI 48909

Re: Psychiatric Residential Treatment Facilities

Dear Kristen Jordan:

On behalf of Michigan hospitals, the Michigan Health & Hospital Association (MHA) appreciates the opportunity to comment on the Michigan Department of Health and Human Services (MDHHS) proposed policy for Psychiatric Residential Treatment Facilities (PRTF) program beginning July 2023. The proposed rule includes important information for entities wishing to establish, license and operate a PRTF in the state of Michigan, which will improve access to behavioral health services and overall quality of life for the sickest children. Our specific comments regarding the PRTF proposed rule are below.

General Information

As entities across the state evaluate the feasibility of establishing a PRTF within their organization, it is imperative that a final policy clearly articulate what type of entities are eligible to participate. Currently, the proposed rule does not define the term "non-hospital" facility, which is also not defined in the Medicaid Provider Manual. To that end, the current policy is written in a way that is not in alignment with the Code of Federal Regulations (CFR) related to Inpatient Psychiatric Services for Individuals Under Age 21, which states "inpatient psychiatric services for individuals under age 21 must be provided by either a psychiatric hospital, a hospital with an inpatient psychiatric program, or a psychiatric facility that is not a hospital."[1] It is also important to consider what other care settings, besides hospitals, provide "inpatient" services. As currently written, behavioral health services provided in a PRTF are considered inpatient, but 'hospitals' are not eligible to become a PRTF. **The MHA is concerned that there is no definition of a hospital within the proposed policy. A hospital as defined in the Michigan Mental Health Code is an inpatient psychiatric hospital. A hospital as defined in the Michigan Public Health Code is an acute care hospital.** The MHA recommends that the policy allow both types of hospitals the eligibility to create and operate a PRTF. An acute care hospital with inpatient psychiatric facilities meets the necessary criteria to operate a PRTF. **The MHA further recommends the department clarify what is meant by a "non-hospital" facility and consider expanding the types of facilities eligible to participate in creation of a PRTF by aligning it with the CFR.** By increasing the types of facilities which can develop or become a PRTF, Michigan can quickly expand access to much needed inpatient behavioral health services for youth with severe mental health needs.

There is language in the proposed rule that is inconsistent throughout the document, which also does not align with the Medicaid Provider Manual, such as the use of "severe emotional disturbance". **The MHA recommends this phrase be changed to "serious emotional disturbance" to ensure consistency of terminology used within the final policy and the Medicaid Provider Manual.**

In reviewing Section 11 of the Medicaid Provider Manual, it states that "for children with intellectual/developmental disabilities (I/DD), services may be provided only in a licensed foster care or

[1] CFR 441.151(a)(2)(i-ii) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-D

child caring institution (CCI) setting with a specialized residential program certified by the state"[2]. Given the language in the proposed policy that PRTFs are required to be licensed as a CCI, it is our understanding that children with I/DD are eligible to receive services in a PRTF, however that is not explicitly stated. **The MHA recommends either the final policy or the Medicaid Provider Manual be updated to clarify and confirm that children with I/DD *may* receive services in a PRTF.**

Common Terms

The current policy states that a "Behavior Treatment Plan (BTP), *where needed,* is developed through person-centered planning process that involves the beneficiary." This is reiterated in Section 7 where it indicates the treatment team should "develop a BTP *if appropriate".* Without clear guidance or criteria as to when a BTP would be needed or should be developed, PRTF providers will be left to their individual judgement about what situations a BTP should be developed. To remove ambiguity and ensure all PRTFs in the state are creating BTPs according to the same set of rules, **the MHA recommends the final policy include a set of minimum criteria or circumstances under which BTPs are required.**

It is unclear as currently written in the BTP section whether the 'specially constituted body' should be organized at the individual facility level or if it is an appointed body that sits within the MDHHS; external to, and independent from the PRTF. **The MHA recommends additional clarity be provided around the specially constituted body to ensure PRTFs know whether they are expected to convene this group or if it is an external entity that they must collaborate with.**

The 'specially constituted body' currently lists a licensed physician and a fully- or limited-licensed psychologist as required team members. To ensure the highest quality of care for vulnerable Michigan youth, **the MHA recommends the psychologist who is required to participate be fully licensed.** This will bring the level of credentialing for the psychologist in line with what is required for the physician counterpart.

The MHA fully supports restricting the use of aversive, intrusive or restrictive techniques when managing behaviors of patients in a PRTF. The draft language indicates any of these items included in a treatment plan, but not supported by current peer-review literature, must be submitted to, and approved by, the MDHHS prior to implementation. MHA feels without clear definitions it will be nearly impossible to meet the needs of the MDHHS Office of Recipient Rights, leading to continuous investigations due to ambiguity. To ensure that PRTFs follow the same rules with submitting BTPs to the MDHHS, **MDHHS should clearly define or set parameters about what is meant by "supported in current peer-review literature**."

Entities will likely be able to substantiate many of the aversive, intrusive or restrictive techniques that the MDHHS is trying to eliminate, through one singular study or publication, which is not the intent. By providing explicit rules about when facilities need to submit a BTP to the MDHHS it will ensure that one facility is not submitting the majority of their BTPs to the MDHHS Department, while others never submit any, even though both contain the same interventions.

For BTPs that are required to be submitted to the department for review and approval, the MDHHS should outline a process for doing so and define a turnaround time for when PRTFs can expect to have an approval on the plan. Further, to avoid delays in patient care and ensure safety of PRTF staff and other residents, **the MHA recommends that PRTFs be allowed to implement the treatment plan prior to MDHHS review,** stopping interventions if the MDHHS deems necessary. This will allow facilities to respond to aggressive or unsafe behaviors in a manner they deem clinically appropriate while awaiting MDHHS approval.

Provider Certification Criteria

[2] Medicaid Provider Manual, *Section 11 – Billing Requirements* - https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

There are two types of PRTF licenses outlined in the proposed rule; one for CCIs managed by the MDHHS and the other for Adult Foster Care (AFCs) managed by the Michigan Department of Licensing and Regulatory Affairs (LARA). For organizations which plan to provide PRTF services to individuals under age 18 **and** over age 18, **the MHA recommends providing clarity in the final rule about how these organizations should be licensed.** As currently written, it is our interpretation these entities should be licensed as both a CCI and an AFC, though that is not explicitly stated within the rule.

It is crucial that MDHHS and LARA identify how they will collaborate to dually-license a PRTF in this instance. To that end, ensuring rules are promulgated in a way that allows dually licensed PRTFs to comply with a standard rule set will alleviate the burden facilities may face in trying to follow two different rule sets, depending on the population they serve. If the rules are drastically different between the two, making it time-prohibitive to follow both, there is a high likelihood that PRTFs may opt to only serve patients under age 18 or patients over age 18 and not both, which would unintentionally limit the availability of PRTF services across the state. Further clarity about the intersection of CCI, AFC and hospital licensure will be crucial to ensure maximum uptake and participation of PRTFs. As the current policy is written, an entity would need three separate licensures to establish a PRTF, with oversight from two distinct state departments. Any effort to minimize this burden is highly recommended by the MHA.

Section 6 of the Medicaid Provider Manual states that "child crisis residential services may not be provided to children with serious emotional disturbances in a CCI unless it is licensed as a 'children's therapeutic group home'"[3]. The proposed PRTF policy requires entities to be licensed as a CCI if they intend to provide services to individuals under the age of 18 and states that PRTFs are intended to provide "comprehensive mental health treatment to children with severe emotional disturbances." That said, the policy does not mention licensure as children's therapeutic group homes. **The MHA recommends the final policy clearly state whether CCIs need to be licensed as a 'children's therapeutic group home' in order to provide services to children with serious emotional disturbances.**

Eligibility

One of the eligibility requirements listed for PRTF admission states the child must have a "severe functional impairment." To ensure consistency of PRTF admissions between facilities and remove any ambiguity about what this means, **the MHA recommends the final policy define what a severe functional impairment means,** or what conditions, limitations or supportive care needs would qualify under this item. If left undefined, it will be left to the subjective conclusion of each individual making the assessment, which will likely result in wide variation between clinicians and PRTFs.

Service Authorization

Section 5 discusses service authorization for individuals requesting inpatient services from a PRTF. Because the MDHHS has issued rules and outlined the admissions criteria which facilities must follow before admitting a patient to a PRTF, this section seems redundant. Since the admission criteria is outlined in the proposed rule, having the MDHHS review all cases that meet the criteria and approve admission to the PRTF not only adds duplication of effort and undue burden on teams that are already short-staffed, it delays timely access to appropriate patient care. **The MHA recommends that beyond issuing admission criteria for PRTFs, no further review or authorization be required.** This would allow behavioral health providers to ensure patients meet all PRTF admission criteria before accepting them to the facility and would be in alignment with the capabilities hospitals have when determining if a patient with an open fracture should be admitted to the hospital – which does not require the prior authorization of the MDHHS before doing so.

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[3] Medicaid Provider Manual, *Section 6 – Denial of Enrollment, Termination and Suspension* - https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Should the MDHHS feel strongly about reviewing and providing approval for admissions to PRTFs, a few specific modifications and questions for consideration have been included below.
As currently written, the process for authorizing services and granting admissions to a PRTF is not clear; particularly as it relates to what entities are required to do which tasks, in what circumstances. It also appears the originating location of the patient is relevant, though it is not consistently mentioned throughout this section.

- Section 5 states that "MDHHS will, *when appropriate,* authorize admissions to PRTF services". MHA recommends clear and concise guidance on admissions policies and procedures. As currently written and verbally communicated, there have been discrepancies between when and if the department is responsible for admissions decisions. Understanding the admissions process is tantamount to effectuating the purpose of the PRTF. Without a clear directive on the admissions process and admissions approvals, providers and patients could experience undue delays, confusion, and difficulty ultimately thwarting the goal of increasing access points for behavioral healthcare**. MHA supports opportunities for increased clarity around the admissions process, approval for admission, and any corresponding policies that speak to how an individual accesses PRTF care.**
    - This statement is contradictory to language included at the top of page 4 of the proposed policy, which states "All PRTF service authorizations will be made by MDHHS." It is unclear as currently written if a service authorization is the same as MDHHS 'authorizing admission.' **The MHA recommends the final policy include more clear language about what circumstances require MDHHS service authorizations and encourages use of consistent language about admissions (using either 'service authorization' or 'request for PRTF admission').**
- Section 5 also states that PIHPs are responsible for the 'certification of requests for admission to PRTF services. As written, this language seems contradictory to the point above, which indicates that MDHHS will provide service authorizations. **The MHA recommends the department provide more clarity about what this PIHP responsibility entails and how it differs from the role MDHHS will play in authorizing services.**
- Further, it is not clear whether the PIHPs are required to process requests for patients currently being treated in a state-operated inpatient facility, or if that is the sole responsibility of the department. **Please include language in the final policy that specifies what entity is responsible for managing PRTF admissions for patients currently residing in a state-operated inpatient facility.**

Section 5.1 indicates the guidelines for authorization and approval decisions have been included in Section 4.2, but section 4.2 is not part of the document. **The MHA recommends Section 4.2, with the aforementioned guidelines, be released in advance of issuing the final policy; or minimally ensure they are included in the final policy.**

Section 5.2 discusses verifying an individual's need for continued stay and outlines the types of providers who are eligible to complete this written order. What is not clear is what entity this individual works for, or whether that is important. In the final policy, **the MHA recommends clarifying whether this individual is an employee of the PRTF, Prepaid Inpatient Health Plan (PIHP), Community Mental Health Services Programs (CMHSPs).**

<u>Provider Requirements</u>

Many healthcare organizations require physicians be board certified prior to providing credentials and privileges for practice within their facilities. This ensures all physicians are held to the highest training and educational attainment, which offers the highest level of care for patients. Thus, **the MHA recommends Medical Directors be board certified, not just board eligible,** as currently stated in Section 7.1.

The proposed policy requires weekly meetings between a large group of individuals to review the care plan, discuss and deliver services. Recognizing service re-authorization is required every 30 days, it is

pertinent that this group convenes and has regular discussions about the progress being made, changes to the care plan and next steps. However, convening a group this size on a weekly basis may present significant logistical and scheduling challenges. Thus, **the MHA would encourage the department to reconsider the frequency with which these meetings need to happen** and determine whether a bi-weekly cadence is adequate to meet the needs of the patient. Additionally, there must be accommodations made to allow for longer treatment plans in certain instances. **The MHA strongly encourages the MDHHS to solicit input from trusted clinical partners are the types of instances when a longer reauthorization period should be considered standard practice.**

Reimbursement

Section 7.2 provides limited information about how payment rates will be calculated and the methodology that will be considered. Based on the language included in the proposed policy, the MHA is under the impression the rates will be tiered, the MDHHS is in the process of developing the requisite rates and the PIHPs would be responsible for reimbursing for services provided at PRTFs. The MHA recommends MDHHS provide additional clarity on this so the reimbursement methodology is clear to all stakeholders involved.

The MHA is concerned about the PRTF rate calculations. Facilities that seek to establish a PRTF need assurance that the rates they will be paid are sufficient to cover the cost they incur to operate a facility, including fixed and variable costs. This includes predictability of patient census. No PRTF should be contemplated without a financial pro forma indicating the expected costs of a facility and the expected revenues to cover those costs. These costs include physical location (brick and mortar), supplies, equipment, staffing, pharmaceuticals and more. More detail and certainty is needed. Patient census, acuity and length of stay are other factors that need to be considered when developing the rates. **The MHA strongly encourages the MDHHS to demonstrate these factors have been considered and accounted for in the final PRTF rates to ensure they are sufficient for facilities to offer these services to vulnerable children.** Additionally, the MHA requests the final policy include more specifics about the following:

- The rate for each tier and information about inflationary adjustments.
- Language indicating the rates are minimums, and that if a PIHP and/or hospital agrees to a higher rate, it should be permissible.
- The circumstances under which each tier will be paid should be described. The MHA is hopeful additional details would help prevent potential payment disputes between parties.

Lastly, providing PRTF services is compressive and expensive. The MHA recognizes the policy outlines a fairly comprehensive rate, however, it excludes non-psychiatric professional fees, vision and dental services, and funding to ensure K-12 education can be provided in the event the patient is under 18 years of age or still required K-12 education. A core piece of PRTF services is ensuring K-12 education is provided and maintained while a qualified patient is receiving treatment at a PRTF. **The MHA strongly encourages MDHHS to consider how PRTFs would fund these services, given that care provided in a PRTF includes both facility, professional psychiatric services, K-12 education, transportation, case management, therapies and other services, as well as how PRTFs would bill for or arrange for other professional, vision or dental services.** The current proposed policy references these as separately billable. The children and adolescents using K-12 education services cannot simply be added to existing school districts. These children are not contemplated in the school district per pupil funding and school districts are not adequately prepared to offer the onsite, integrated education programming necessary for children and adolescents receiving treatment at a PRTF.

Finally, the MHA strongly encourages the MDHHS to consider the process being used to implement this policy. Upon review, it appears there are critical pieces that require updates and feedback from clinicians before implementing the final policy. Admissions decisions for PRTTF services should not permanently remain under the purview of the MDHHS. This would undoubtedly lead to significant delays to care for patients in critical need and add another level of oversight to a program that is already proposed to be heavily regulated. **The MHA strongly recommends the MDHHS issue this policy with the intent to**

revise it within 3-6 months after initial implementation to quickly incorporate necessary changes as MDHHS, PIHPs, CMHs, PRTFs, inpatient psychiatric hospitals and acute care hospitals discover challenges, successes and missing directives in the initial rule.

Thank you for the opportunity to comment, and we look forward to engaging with the MDHHS on the implementation of this policy. Please be in touch with any questions.

Sincerely,

Lauren LaPine
Senior Director, Legislative & Public Policy
Michigan Health & Hospital Association