Rhode Island Executive Office of Health and Human Services
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Responses to Public Comments: Proposed Medicaid State Plan Amendment (SPA) for the Psychiatric Residential Treatment Facility (PRTF) Payment Methodology

Public Comment Period: March 4, 2021 – April 3, 2021

Category	Nature of the Comments	EOHHS' Response
How PRTF services fit into the overall child welfare and children's behavioral health system for the service	1. PRTF is a restrictive treatment modality. There is no material provided on the context, data, or planning for use of this level of care including the ages and target populations. 2. PRTF programs must be developed in the context of a comprehensive array of behavioral health services, including Intensive Community-Based Treatment (previously proposed as an insurance framework by RICCF), Residential Treatment Centers (RTC), Therapeutic Foster Care, and clinically enhance group care. We are concerned that adding this high level of care without simultaneously addressing enhancement of other intensive home- and community-based options, youth will be placed in PRTFs for lack of those less restrictive options or stuck at the PRTF level on the discharge end. For youth who are currently in RTCs and do not require PRTF, transitioning current RTCs to PRTF begs the question of where youth with similar needs will go. The need has been consistent, with 169 youth in residential treatment as of April 1, 2021 compared with 156 in March of 2019, according to DCYF data. There is not sufficiently intensive community-based treatment, and the group home and foster care systems are not sufficiently resourced to meet potential demand. For PRTF to be successful, investments to create intensive community and home-based treatment (ICBT), ensure sufficient clinical capacity, staff development, etc. of all existing group care options, as well development of therapeutic foster care beyond the current level system will be necessary. 3. The regulations do not list the nature and types of issues they provider should be prepared to address, and what mix of services and space may be needed if similar patients cannot be together or require special arrangements. This should be clarified. For example, a different physical plant construction is needed for fire setters, and a greater level of security may be needed to care safety for those who have been involved with trafficking. Drug Treatment may be possible, but then having those who have issues with the sale of drugs in the same place may create unintended outcomes. The nature of therapies and patient demographics needs to be clarified. It should also be understood that most all states, even those with much larger continuums of care do send youth out of state for care because the cost of care for a small population is overwhelming to the system. Further, research has indicated the management of proper release time during stay to prepare for return home is the greatest predictor of success, not closeness to home or other interactions (Boys Town research center).	DCYF has seen a consistent need for PRTF services in Rhode Island that can serve female youth ages 14 to 21 who are experiencing significant behavioral health conditions that cannot be treated in a family setting or in a lower level of care. Currently, many of these adolescent females are being placed out-of-state due to a lack of appropriate local treatment options. Historically, approximately 25 or more female adolescents with severe behavioral health conditions have been placed in residential treatment out-of-state at any point in time, and an additional 6-8 adolescent females have remained in a psychiatric hospital while a bed at an out-of-state residential facility becomes available. Many of these adolescent females have histories of chronic trauma, complex psychiatric conditions, self-injurious and assaultive behavior, elopement, being the victim of sex trafficking and sexual assault, and multiple placements in lower levels of care. EOHHS and DCYF fully agree with and support the need for intensive home-based services and high quality lower-levels of care, including community group homes, to provide treatment and support to youth in lower levels of care, whenever possible, and to obviate the need for placement into a PRTF. DCYF currently funds 45 in-state, non-PRTF congregate care sites, 10 therapeutic foster care programs, and over 35 home-based services. Admissions to a PRTF should only occur if lower levels of care have been explored and determined unable to meet the clinical needs of a youth. It is important to note that the notice of public comment was for a proposed Medicaid State Plan Amendment to codify the payment methodology for PRTFs and is not a proposed regulation. Additionally, EOHHS and DCYF do not plan to provide specific requirements about particular settings that are beyond what is already contained in the PRTF certification standards and DCYF residential licensure requirements at http://www.dcyf.ri.gov/licensing-child-care/documents/dcyf-residential-child-care-regulations.pdf.
Accepting Referrals	4. Given the varied and serious needs of different target populations, the "no eject-no reject" policy is not appropriate to this level of care. A youth should only be referred to a PRTF and programs should only be required to accept clients based on match between the youth's needs and the program's areas of expertise. If the placement is not working for the youth or the program, the situation should be brought before the review team for resolution in place of a 'no eject, no reject' policy. 5. The expectation that a provider should have a policy that could potentially put their organization, the youth they are serving and their staff at risk is heavy-handed. In addition, the provider is in the best position to determine if their programs can meet the needs of the youth referred. The idea that the State can override a private organization's decision is unreasonably excessive.	Given the nature of PRTF services as an inpatient benefit, it is the expectation that a PRTF will admit a youth if the service is deemed medically necessary through certification by an appropriately qualified psychiatric team. Such decisions would be subject to bed availability and as is consistent with the population that a PRTF is licensed to serve. The psychiatric team certifying that the service is medically necessary must include a physician and have competence in diagnosis and treatment of mental illness, preferably in youth psychiatry, and have knowledge of the individual's situation. As stated in the draft PRTF certification standards, any referral would be subject to a review process if a facility feels that it cannot adequately meet the needs of a referred youth. In such instances, the facility should submit a detailed written explanation as to why it does not feel it can provide care and treatment to a youth. DCYF is committed to working collaboratively with providers to decide cooperatively upon referral dispositions, whenever possible.

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	6. As a matter of law, these regulations indicate that the state has the authority in the no reject/no eject clause to overrule a private, incorporated, organization with its own board of directors, fiduciary responsibilities, and liabilities, and ask them to take on all liability and risk themselves for a placed a child they do not believe they can serve safely. While a given provider in contracting may be willing to agree to such a term, should the state as a matter of regulation overrule the autonomy of a private organization? If so, how is the state sharing the risk? Further, as discussed below, there is no profile of patient, or scope of treatments/services desired. There is no understanding of the interplay that may be needed with the family court if the youth is also involved in juvenile justice issues. 7. It is not clear during the entire process which health care professional has final decision authority for the placement/acceptance or continuation of a child. 8. If this no eject no reject clause, which does not appear to be a requirement of Medicaid is included, it would also be best paired with a regulation obligating the State to remove/replace a child in a short period of time (as soon as possible; 5-7 days max) should the provider no longer be able to meet the needs of the child (emergency replacement), or maintain safety for that child or other children that are in the program at that time. 9. The state agency is responsible for maintaining a system of care and beds at various locations and levels of need to meet the needs of young people and should not shift that responsibility to the providers who can not realistically be ready for any child at any time with any conditions. That is why a larger system managed by the state exists.	Any PRTF should be prepared to admit youths who are struggling with acute and, in some instances, dangerous mental health conditions and behaviors and who may be self-injurious , assaultive, and victims of sex trafficking; engage in property destruction, and who may be at high risk for elopement. The PRTF service within the state of Rhode Island constitutes one of the most intensive level of behavioral health care available outside of a hospital setting. A PRTF provider should be ready to address extremely complex and acute behavioral health needs for any youth referred who matches the population a PRTF is licensed to serve. The budget submitted to DCYF for rate setting purposes should reflect this level of care.
Referral Process	10. DCYF's Division of Community Services and Behavioral Health (CSBH) is the only review entity making placement decisions mentioned. We believe there should be a multi-disciplinary review team including both psychiatric and community-based provider expertise; this is especially important as PRTFs are not only accessible to youth known to DCYF. 11. The state should also take great care and have strong safeguards against the over classification of youth for PRTF services because of the funding source rather than the true needs of a child. This level of service is not equal to the current RTC level care offered by some providers in the state and should be an additional services for additional beds needed, not a recasting of current services for fiscal options.	For all admissions to a PRTF, a multidisciplinary team must certify the need for the service. Per federal PRTF regulations, this team must include a physician; have competence in diagnosis and treatment of mental illness, preferably in youth psychiatry; and have knowledge of the individual's situation. Non-emergency admissions must be certified by an independent, multi-disciplinary team that may include psychiatric or other professionals who work at a psychiatric hospital or within a community. For emergency admissions, the certification must be completed by the team responsible for the plan of care within fourteen days of the admission. Admissions will only be possible to a PRTF if the clinical professionals involved with the multidisciplinary team feel it is necessary and a youth cannot be served appropriately in a lower level of care.
Emergency Placements	12. Emergency placement will require the provider stand up and stand ready with separate program space and staffing at all times. This can be included in the program design but is not simply another bed or empty bed in the program. If you will, patients coming to the hospital that are not planned admissions go through the emergency room for stabilization and review prior to being given a bed in ICU or pediatrics, the same would apply here. The frequency of use does not change the need for the proper level of care and service. Alternatives using DCYF's assessment and stabilization centers, or other behavioral health options should be considered as an alternative.	DCYF anticipates that most admissions to a PRTF will be done on a planned basis, but, in limited circumstances, an emergency admission may be requested when a youth is in need of immediate, comprehensive behavioral healthcare in a residential setting and the youth appears to meet PRTF certification requirements but the youth does not meet psychiatric hospitalization criteria. All youths certified as needing PRTF level of care, whether on a planned or emergency basis, will require close supervision and intensive services and supports given the acute and persistent nature of the behavioral health conditions they face. Due to the level of acuity that may be present at any time, the level of staffing and support needed for emergency admissions should be similar to that needed for youths who have already been receiving PRTF care for a period of time. Budgets submitted to DCYF for rate setting purposes should reflect this level of support.

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		PRTF services constitute a much higher and more intensive level of care than DCYF-contracted assessment and stabilization services. DCYF does not anticipate requesting emergency admission to a PRTF for a youth who can be cared for appropriately at an assessment and stabilization center.
Discharge from a PRTF	13. There should also be clear understanding of how a child will be discharged from the program and become DCYF's responsibility for replacement or taking on all liabilities for the child remaining in a level of care and service that is no longer appropriate for them.	Any youth who cannot be re-certified by the treatment team at a PRTF as needing that level of care will need to be stepped down. Recertification by the PRTF treatment team is required every 60 days. The need for continued PRTF treatment should be discussed at every full treatment team meeting. If it is anticipated that a youth may not need continued PRTF treatment when the next 60-day recertification is required, then a PRTF provider should notify DCYF immediately so that planning can commence for stepdown option.
Minimum facility size requirement	14. Certification standards should not require PRTF facilities to be of a certain size in order to be certified. Rhode Island should instead allow congregate care settings of a variety of sizes, whether 6 bed facilities, 8 bed facilities, 10 bed facilities, or larger to be certified as PRTF sites. This would allow greater integration into communities, leverage existing licensed congregate care facilities, and allow for Rhode Island to have a more flexible response and to better serve youth who have unique needs.	Given the cost-based reimbursement methodology and costly nature of necessary, intensive, onsite medical, psychiatric and other clinical services, having small group home facilities serve as PRTFs would be cost prohibitive. It is important to note that the notice of public comment was for a proposed Medicaid State Plan Amendment to codify the payment methodology for PRTFs and is not the certification standards. DCYF will take the public comments into consideration in its review of the draft certification standards.
Alignment with licensing, other regulations and accreditation standards	15. Certification standards should align with existing licensing and accreditation standards where applicable, to avoid duplicative and contradictory standards for PRTF locations. 16. There are clear conflicts between these regulations and those mentioned in the last paragraph as having to meet. Clarification on the give and take between all three sets of regulations and their hierarchy would be helpful.	EOHHS and DCYF agrees with aligning PRTF certification standards with licensing and accreditation standards, wherever possible. DCYF is not aware of any conflict between the PRTF certification standards and existing state regulations. PRTFs will need to be licensed by DCYF as a residential child caring facility and meet the provider certification standards to be approved to enroll as a Medicaid provider.
Serving youth according to gender identity	17. To reduce discrimination, PRTF certification standards should align with best practices where serving youth of all races, ethnicities, and gender identities is concerned. For example, PRTF certification standards should ensure that youth are placed within facilities based on their gender identity, rather than their assigned gender at birth. This will allow youth who identify as a gender other than the one assigned at birth to be supported in the PRTF process.	EOHHS and DCYF fully support placing youth according to their gender identity. The gender identity to be served at a PRTF would be determined through the license issued. DCYF licenses allow for placement by gender identity.
Non-Medicaid Eligible Youth	18. Those in need of PRTF level of services may have private insurance coverage, and it is unclear how those youth are eligible for this model.	The PRTF service is a specific, Medicaid covered benefit.
Certification vs. Contract	19. If these regulations are proposed to meet Medicaid State Plan Amendment, the scope and issues should be related to those required for the plan amendment. Other items should then be issues for DCYF or other service contracts rather than in regulations. 20. The regulations only specify following the building bridges initiative, which is a philosophical framework, not specific practices. This should be considered for contracting and scope of work rather than regulations as the severity of need of youth at this level. While including family and working to have the youth return home are good philosophical positions, the needs of the youth may override. If you will, few patients go from the ICU level of care directly home (even with home health care) to families without step down in the hospital or to a rehabilitation facility. This should be understood as the potential reality here as well.	It is important to note that the notice to the public was for a proposed Medicaid State Plan Amendment and was not for any regulations nor the draft certification standards. DCYF will not be entering into a contract for PRTF services. Any willing provider who is able to meet the PRTF certification standards and comply with the payment methodology requirements will be able to be certified and become a PRTF. Since contracts will not be issued, requirements, such as those related to Building Bridges, are being included within the PRTF certification standards. DCYF is confident that many recipients of PRTF services will be able to be successfully reunified with family or discharged to foster families, and a model consistent with the Building Bridges principles should be adopted by a PRTF to support timely discharges to family settings.
Facilities Improvements and Other Capital Investment Costs	21. Given the limited residential campus facilities in the state, facility investments should be considered in the available cost categories; or another funding source should be made simultaneously available. 22. Would further suggest that PRTF costs which are facility-related updates and upgrades be considered for reimbursement to providers. Instead of only reimbursing providers on a per diem basis (per youth per day), Rhode Island should consider reimbursing costs to modernize or improve facilities. This would again allow Rhode Island	Facility renovations and other similar capital investments directly related to delivering PRTF services may be included in the annual budget to be used for determining the effective per diem rate as long as the renovation and other costs of the fixed asset are properly depreciated according to generally accepted accounting principles (GAAP).

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	more flexibility, would allow providers to transition from congregate care models to the PRTF, and would assist Rhode Island with generating enough capacity to reduce over-utilization of acute-care settings. 23. The regulations will create the need for considerable capital investment by the provider. There is no mechanism to fund the needed investment upfront, or consideration for stability to allow for such investment's financing over time. Consideration of how to manage this should be considered in the funding formulas proposed.	
Impact of Fluctuations in the Census	24. How does this pertain to an organization that has already been a PRTF provider for two years? When determining the rate, you intend to use 85% utilization for that determination. For organizations that have sustained historical data regarding utilization that falls below the 85% threshold, how many years prior will be used to make that determination? 25. "providers will be paid on a "cost basis." However, the formula creates a census based per diem that could cause costs to be uncovered by fluctuations in census. While annual review may allow for adjustments for the coming year. Some method of correction for low census should exist and be available in real time during the fiscal year. It will need to be on a very short timeframe given the low margins (max 5%) in the funding mechanism.	For the purpose of determining cost-based per diem rates that will be in effect following the first 6-months of operation, a utilization rate for available beds of 85% or higher shall be used unless a complete and proper justification is provided to and approved by DCYF. The determination to approve an anticipated utilization rate below 85% shall be made on a case-by-case basis according to data on overall system demand for out-of-state residential placements, psychiatric hospitalization rates, demand for PRTF services and any other relevant factors. A utilization rate below 75% may not be used for calculating per diem rates. Providers may request rate adjustments at any time if significant changes in costs or other circumstances occur.
Annual Cost Report and Reconciliation:	26. The way in which determination of repayment is described in this document is different from what DCYF has stated about using staff vacancies to determine repayment. Can this be clarified? This states that repayment must be made within 90 days. The PRTF certification standards state that repayment must be made within 6 months. There is inconsistency that must be resolved. Repayment in a 90 day window could create a hardship for an organization that could be experiencing losses in other programs. 27. Excess of 5% in payments is a very tight margin given the nature of the program, census and capital funding needed. You allow for 15%-25% in census planning, a similar allowance to support that swing would be appropriate here. In general, if a per diem rate is created, it would seem a generally good business practice to allow for reinvestment of saving achieved through any new efficiencies. 28. Relatedly, if the state will only allow a margin of 5%, then will it also offering fiscal support of an approved budget should a business reality create a shortfall of a given year, since basically you are not allowing for any operating reserves for operational, capital, or other improvements in the program. Why penalize management improvements by taking the saving away when they may best be reinvested in the program. Please allow for such a mechanism, perhaps with a cap. Massachusetts allows for 20% reinvestment of unexpended funds, for example. 29. In section "b" percentage should be capped at the same as the budget's allowable margin. Noting that it may be important in some cases to not look at percentage, but actual dollars. Further, it is not clear, but the percentage should be of that line item in the budget not overall budget. 30. Cost reports are required in a time frame that will not allow for audit review. There is no requirement for CPA review/audit of the program on an annual basis, correct? If so, please clarify in the regulations.	The 5% threshold and 90-day period to repay payments made in excess of costs incurred were determined to support the fiduciary responsibilities of the state and are considered fair and reasonable. The PRTF certification standards do require an annual audit that complies with federal "Government Auditing Standards" and any applicable state and federal law.
Determination of Reasonable	31. This states that providers are expected to establish operating practices that assure costs that a prudent buyer pays for a given service. How is that determination made? How does the state determine costs in excess?	The federal Office of Management and Budget (OMB) "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Final Rule (Uniform Guidance) from December 26,

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and Allowable Costs	32. Section 4. More detail is needed about the metric for "allowable" costs. A standard will need to be determined to allow for proper planning and growth. Any expense approved in the budget for rate setting should not be subject to discount as not allowable at the end of the year's fiscal review. It will have already been approved. There is no clear understanding of how inflation, salary adjustments and so on become included in the largely historic cost-based process. These adjustments are vital for the success of programs like this. Rate review should be tied to a review of Consumer Price Index for inflation as well as labor department statistics on salaries. 33. Comparative analysis is a challenge for expenses and needs clarification. There will be cost differences between program and purchasing that will need to be allowed. The nature of the comparison will need a review and response protocol rather than individual reviewer's opinion which may create inconsistencies. I would remember also that it is very hard to be the same across providers, just like each municipality covers basically the same services with their taxes, but they vary greatly from community to community. Standards and framework will be needed here.	2013"; 2 CFR Part 200 (Omni Circular) provides guidance with regard to certain items of costs, including information as to whether certain types of indirect costs are allowable or unallowable. Additional details are available through the following link: https://www.federalregister.gov/documents/2013/12/26/2013-30465/uniform-administrative-requirements-cost-principles-and-audit-requirements-for-federal-awards
Prospective Rate Adjustments	34. This states that the operating costs must have been incurred for a period of 3 months to establish proof of a need for an increase. Adjustments granted as a result of a request filed within 120 days after the costs were first incurred and be made retroactive. Certainly appreciate this clause, however, in current DCYF contracts, we are able to request a meeting within 45 days to request a rate adjustment. If a provider has to wait this length of time it could create a financial hardship from which it would be impossible to recover. 35. The criteria is established in the section. DCYF "will grant" rather than "may grant" should be the opening language.	The 120-day period for considering cost increases is deemed necessary so that DCYF can determine that the cost increases are not temporary and limited in nature. DCYF is seeking to avoid per diem rate increases that may result in overpayment.
Impact on the State Budget	36. The state needs this level of care for young people. It will shift some current residential beds to a new status and allow them to be funded without/with less state dollars. That increase in federal expenditure should be understood, as well as the planned use of the savings for other residential programs or DCYF services.	This proposed SPA is to codify the existing payment methodology for PRTFs in Rhode Island. As such, no additional expenditures or savings are anticipated as a direct consequence to this SPA.