PCPA

Pennsylvania Community Providers Association

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Memo

To: Shaye Erhard, Department of Public Welfare
James Smith, Independent Regulatory Review Commission
From: Connell O'Brien, Pennsylvania Community Providers Association
Date: November 22, 2010
Re: Proposed Regulations: Residential Treatment Facilities
Pennsylvania Bulletin Publication Date: October 23, 2010
IRRC # 2878, Regulation # 14-522
PCPA Comments, Concerns and Suggestions

The Pennsylvania Community Providers Association (PCPA) is a membership association representing over 225 community-based agencies that provide mental health, intellectual disability, substance abuse, children's, and other human services. Members cover all 67 counties in the Commonwealth and serve over 1 million Pennsylvanians each year. The vast majority of our members are providers of child and adolescent psychiatric outpatient, partial hospital, residential treatment and inpatient services within their community's mental health service system. Our membership also includes county agencies, behavioral health managed care organizations and local education and child welfare agencies. PCPA is the largest statewide behavioral health trade association in the United States.

PCPA is pleased to offer our comments, concerns and suggestions for the proposed regulations for residential treatment facilities (RTF). Many of the PCPA comments and recommendations were developed in meetings with many providers of residential treatment programs who would be impacted by the proposed regulations. Input also came from providers of community based services and psychiatric hospital programs. The expectation of PCPA is that new program regulations will reflect the intent to ensure the safe and appropriate care and treatment of children and adolescents served in the commonwealth's RTF programs. Provider agencies are responsible for regulatory compliance and for successfully meeting accreditation standards. Providers carry the medical, ethical, administrative and fiscal responsibility for these programs and, most importantly, for service quality and effectiveness. The ongoing role of the provider community in the process of development of regulation is critically important.

PCPA is pleased that the proposed regulations serve to consolidate many of the state bulletins and policy clarifications created over time. We are also please that the Department seeks to promote family involvement in RTF services and also add Community Residential Rehabilitation (CRR) services to the community continuum of service options. However, of great concern is that several of the key elements of the proposed regulations would dramatically impact the availability of services, have an adverse economic impact on many agencies, their employees and local communities across Pennsylvania.

If proposed staffing requirements are implemented they will create great strain on the mental health labor pool and on community based services while substantially increasing the cost of residential treatment. The proposed regulations also include an array of other requirements that would substantially drive up the cost of care by adding new service program elements and by reducing economies and scale. In several cases the added program elements will include operating costs that are not allowable under federal Medicaid regulations. In the context of the Medicaid managed behavioral health care waiver with the federal government (HealthChoices) several of the fiscal requirements along with the dramatic reduction in bed capacity will preclude the counties and their managed care partners from effectively establish the required network of service providers for both RTF and additional community based mental health services needed to meet their contractual obligations to the Commonwealth. This precipitous reduction in service capacity will jeopardize the health and safety of children and adolescents who, based on the Department's own medical necessity criteria require treatment at the RTF level of care. It is our expectation that the Department will revisit and revise the final regulations to mitigate the extreme adverse economic and fiscal impact on agencies, communities and the Medicaid program as well as the real risk to the safety and welfare of mental health consumers who will be impacted.

Comments, suggestions and objections pertaining to the Transmittal Document:

Section I

Paragraph 9, A:
The 30 day comment period is too short for proposed regulations of the length and complexity (166 pages) even without the substantial analysis of the economic impact on the Medicaid Program, Behavioral Health Managed Care and county operations and resources. We recommend that the Department of Public Welfare (DPW) exercise its prerogative to gather additional input from stakeholders, especially providers of child and adolescent mental health services beyond the November 22 deadline for submission of public comment.

Paragraph 9: E:
As noted above the complex implications of the proposed regulations and the creation of new services both, bed based and community based, to replace the eliminated bed capacity could not reasonably be accomplished in 12 months.

Paragraph 10:
The OMHSAS Children's Advisory Committee, by virtue of its structure and membership lacks the reliable and consistent level of expertise and the ability to monitor regional variations and differences in service needs, service capacity and the regulation's impact on a range of economic and operational issues related directly and indirectly to these regulations. PCPA recommends a more comprehensive review process and entity that includes a significant membership of individuals with expertise in health economics, mental health research and practice.

Paragraph 10:
The monitoring of the regulations should be assigned to the office of the Deputy Secretary of Office of Mental Health and Substance Abuse Services (OMHSAS). The complexity of the operational, compliance and fiscal impact of these and regulations calls for monitoring at this higher level of authority and responsibility. It is also important to note that a Children's Bureau has not existed on a consistent basis within the OMHSAS structure and is therefore not a reliable level of government for monitoring regulations.

It is important to note that a federal regulation for an accredited RTF requires the involvement of the state Department of Health (DOH) in the regulatory monitoring process. This collaborative relationship should be managed at the highest levels within DPW and DOH. Historically, in spite of the existence and content of a Memorandum of Understanding in this regard the level of collaboration and coordination has been highly problematic. Resolution and regulatory guidance is critical to addressing current and future issues related to the uniform and consistent clarity and monitoring of regulations.

Section II, Statement of Need

PCPA is pleased that the Department is proposing regulations "needed to codify minimum licensing and program standards, requirements for participation in the Medical Assistance Program." However, the proposed regulations in light of the standards and recommendations of such organizations as the American Academy of Child and Adolescent Psychiatry, the National Association for Children's Behavioral Health and the National Association of Psychiatric Health Systems suggest that the proposed regulations, especially staffing levels and credentials go beyond recognized program standards.

The statement of need also references the department's stated intent that the "proposed rulemaking benefits the approximately 6000 children per year under 21 years of age who need mental health services with a more intensive level of care than is available in community settings." The proposed regulation would force a substantial and unmanaged reduction in RTF capacity with no plan for the creation of alternative "more intensive level of care for those 6000 children and adolescents." The department has not addressed the manner in which the need for this level of services will be addressed. This will create a real threat to the health care, safety and welfare of children and adolescents related to the lack of medically necessary services.

Paragraph 14: The scientific data, studies, references used are extremely limited and do not reflect broadly recognized and available research and information that should be used to guide this level of care (see organizations previously cited). The documents cited are highly selective and not broadly representative of the field. The department should more fully review the available literature and reflect that review and consideration in establishing "minimum licensing and program standards, requirements for participation in the Medical Assistance Program."

Paragraph 15: While the department provides general numbers of agencies that will be adversely affected by the proposed regulations it fails to provide any specific information regarding the projected bed reductions, names of agencies, county locations, counties served or the manner by which the 6000 children and adolescents will be served following the reduction in bed capacity.

The department fails to present the data reflecting the adverse economic impact of the regulations on the local economies or displaced employees as a consequence of the proposed regulations. The adverse economic and employment and corporate viability impact of many agencies is not represented in the department's submission. The department should provide specific information regarding the agencies, counties, communities and numbers of individuals that would be adversely impacted along with both dollar estimates for the immediate and general economic and employment impact. The department should provide the state, regional and county level plan for meeting the needs of children and adolescents who require this level of clinical care.

Section III Cost and Impact Analysis

Paragraphs 17, 18, 19, 20 and 21:
The analysis and cost impact assumptions provided by the department for sections 17, 18, 19, 20 ("not applicable" "no fiscal impact") and 21 are without foundation and are likely inaccurate based on the experiences and projected impact of changes in staffing requirements, levels of clinical acuity, current service utilization levels, reduced economy of scale, increased reliance on yet to be created levels of residential care and other factors. The department must be accountable for the development of a much more detailed analysis of the fiscal and service system impact of these regulations at the agency, county and state level. Currently RTF programs are required to submit a cost report annually and these should be used as the foundation for the department to formulate a realistic economic impact assessment.

Paragraph 21:
The underlying assumption in paragraph 21 is highly speculative and not substantiated in any way. It is also important to note that under the (unregulated) MA HealthChoices managed care model there are no mechanisms to ensure that the changes in costs (both allowable costs under MA and non-allowable costs) will be reflected in the negotiated, unregulated rate setting process. Current experience in HealthChoices suggests the cost-rate relationship will be problematic and threaten the viability of RTF services.

Paragraph 24:
Several program requirements are for services and activities that include costs that are not allowable under federal Medicaid regulations. This information is not reflected in the department's submission. PCPA is not aware of any HealthChoices related policy or contractual requirements that would ensure that costs that are not allowable under federal Medicaid standards would be fully compensated in the per diem rate established between RTF providers and HealthChoices behavioral health managed care entities.

Section III, 25:
The proposed regulations will result in the closure of programs and services with the related displacement of professional and para-professional staff. Several of the programs impacted by required or unintended bed eliminations are located near the boarders of New Jersey, Maryland, Ohio and New York. With the reductions in employment related to these proposed regulations and the increased demand from other states resulting from federal legislation related to behavioral health parity and health insurance reforms it is likely that these regulations will further exacerbate the current patterns of migration of health care professionals, especially psychiatrists, nurses and social workers to other neighboring states.

Paragraph 27:
The department states that the greater costs related to "accreditation requirements, number of units per facility, staffing ratios, higher staff qualifications and increased training requirements" will be addressed by "rate setting policies." PCPA is not aware of any Medicaid fee for service policy or Medicaid HealthChoices policy or contractual requirements that would ensure that additional costs related to these regulations would be fully compensated in the per diem rate established between RTF providers and HealthChoices behavioral health managed care entities. The department must identify and include these policies, regulations and contracting standards in the regulations.

Comments, suggestions and objections pertaining to the *general provisions* of Proposed 55 Pa Code Chapter 23, Residential Treatment Facilities:

Purpose of Regulations

The recognition of the value and applicability of accreditation standards has been a long established standard for federal regulations and in the commercial insurance credentialing process and is supported in general by PCPA. PCPA would like to see the proposed regulation used to simplify the current complex, redundant and expensive licensing and credentialing process.

One stated intent of the proposed rule making is to establish "MA payment conditions." There are numerous elements of the regulations and of good practice that are not considered "allowable costs" but are necessary for both regulatory compliance and participation in MA through the HealthChoices contracting and credentialing process. Proposed regulations must include standards and requirements for payment and purchase of services that fully reflect the costs associated with regulatory compliance and community standards of practice.

The potential for the re-establishment of Community Residential Rehabilitation Group Homes within the MA program under the proposed regulations is welcomed. This proposed service level must be considered in the development of a comprehensive plan by the department prior to the implementation of any regulation that reduces the number of available RTF beds in the commonwealth. Such a comprehensive plan should reflect at least the following:

- The region specific projected cost of creating a CRR Group Home including the initial capital cost, legal costs associated with zoning and community reactions, ramp up costs, projected operational costs related to a small facility type, expanding personnel costs related to recommended staffing models and training requirement, expanded personnel costs related to the projected impact of MA expansion and behavioral health care service expansion related to recent federal legislation. (This information was absent from the submission document).
- Region specific local impact projected bed reduction and program closures related to the unit and facility bed limits proposed.
- County level plans reflecting new service and referral resources necessary to replace any bed reductions and program closures.
- Funding sources necessary for the initial real-estate acquisition, construction, furnishing, equipment, staff recruitment and training necessary prior to program operations that would be paid for on a fee for service basis.

Requirements

23.11-23.22
As previously noted the limitation on bed capacity will result in substantial cost increases that will adversely impact the Medicaid HealthChoices and fee for service programs by eliminating operating efficiencies related to current economies of scale. The limitation on bed capacity will also result in substantial fiscal impact on the nearly 100 RTF providers as well as a significant adverse economic impact on local employment and local economies where these programs are located. The substantial reduction in RTF bed capacity will significantly strain both the community based ambulatory mental health and hospital based mental health service systems and place at risk the health, safety and welfare of children and adolescents in the community.

PCPA strongly supports the promotion of strategies that will "increase the opportunities for families to have regular contact with the child and staff, as well as to collaboratively develop a family participate plan." The reduction in local bed capacity will adversely impact this effort by promoting RTF placements in the remaining programs that will be located at a significantly greater distance from the child's home, family, school and community. It is also important to note that federal and state Medicaid regulations require that health care services be provided to the patient and that costs related to services to other individuals (parents, siblings, grandparents, etc.) and the related costs are not allowable under existing regulations. It is not reasonable or feasible for regulations to require services and related costs for a Medicaid program that are not allowable or payable by Medicaid.

23.51 – 23.62
PCPA supports reasonable efforts to improve the staffing capability of all service providers. In several sections the proposed staffing requirements and staff training requirements should be revised and refined to reflect the current and projected labor pool for mental health professionals and workers. The increased costs related to any change in staffing and training requirements must be "costed out" to accurately reflect the real cost of care and of the regulatory changes to the Medicaid program.

23.201 -23.206
PCPA has long supported the position that restrictive procedure be used only in emergency situations and that the be used safely and humanely.

23.281 – 23.295
PCPA supports the expectation that RTF programs maintain accreditation by COA, CARF or JCAHO. However, one opportunity created by accreditation standards is that those standards establish a quality of care and operation structure that should reduce and simplify the regulatory, credentialing and quality assurance process. In this case the proposed regulations impose the cost to the provider of maintaining and complying with accreditation standards and with remarkably complex, prescriptive and extensive regulation. This approach places an unnecessary burden on both the provider agency and on the state's regulatory compliance resources. PCPA recommends that the proposed regulations be substantially reduced and simplified in light of the requirement for accreditation.

23.301 – 23.351
The rate setting policy and cost reporting requirements included in the proposed regulations do not reflect the HealthChoices waiver structure in which per diem rates for RTF services are established solely through a rate negotiation process between the RTF provider and the

county/behavior health managed care organization. This condition precludes any assurance that the rate established will be based on allowable costs, actual costs or any other objective rate setting approach. There is no regulatory, policy or contract standard to ensure that cost based rate can be expected. This market driven model of service procurement in the absence of a mechanism to ensure the adequate availability of RTF services at a rate that will sustain the service constitutes a danger to the service system and to the health and welfare of those served by these programs.

Comments, suggestions and objections pertaining to the *specific provisions* of Proposed 55 Pa Code Chapter 23, Residential Treatment Facilities:

Subchapter B. Licensure/Approval Requirements

23.12 Inspections and certificates of compliance:
In light of the regulatory requirement that an RTF attain accreditation status this section should create a "deemed status" simplification for inspection, certification and credentialing by the department and by the department's contracted managed care organizations. Currently the redundant and costly inspections and credentialing of RTF facilities each year by several separated departments, program offices in the DPW, several managed care credentialing units and by accrediting organizations is extremely duplicative and makes poor use of health care funding and valuable staff time within the state, county and provider organizations. The promulgation of regulations is an opportunity to make this process more effective and efficient. This section should address the relationship and process related to the role of the Department of Health in the inspection and compliance process. This section should address the role, responsibility and activity of the Bureau of Program integrity related to RTF inspection and certification.

23.14 Maximum capacity:
The limitation on facilities of "4 units of 12 beds each for a total of 48 beds" is arbitrary, beyond the stated scope of the regulatory process. As noted previously the limitation on bed and unit capacity will result in an adverse impact on up to 100 agencies, their employees and the communities in which they are located. The cost of facility, architectural and related maintenance costs related to compliance with this section are also note reflected in any aspect of these regulations or related cost impact statements. The reduced capacity will also place at risk the safety, health and welfare of children and adolescent who meet the Medicaid medical necessity criteria for admission and continued stay for the RTF level of treatment. The limitation has no benefit in the clinical care or operations of a facility. In addition:

- The limitation would cause unnecessary and unwarranted hardship for numerous agencies and corporate entities for no reason.
- The limitation would cause unnecessary and unwarranted hardship for employees and communities impacted by job reductions and displacements.
- The limitation would cause unnecessary and unwarranted hardship for children and families who would need to be served in RTF facilities at greater distance from their homes and communities. Reduction in local service capacity would result in increased travel time and costs and potentially impeding the child's transfer and transition to community based mental health care, return to school and successful recovery.
- The department has failed to provide an impact analysis, plan for meeting the service needs that would result from reduced service capacity or a plan to replace or effectively alter the service system so as to insure the availability of medically necessary mental health services in the MA service system.

23.20 Consent to treatment:
The proposed regulations do not provide information or guidance on Act 147 which amended the Minor's Health Care Consent Act to allow for parental consent on behalf of a minor up to age 18 for admission into inpatient mental health treatment and due process for the minor to object. While the law is not clear about the status of an RTF as a mental health inpatient service, federal standards view an accredited RTF and a non-hospital inpatient program. RTF programs in Pennsylvania are being expected to manage consent to treatment in a manner that conforms to

Act 147. It is essential that this be address as it constitutes a possible conflict with or duplication of other statues referenced in the proposed regulations.

23.21 Confidentiality of records:
The proposed regulations do not provide information or guidance on Act 147 which amended the Minor's Health Care Consent Act to allow for parental consent on behalf of a minor up to age 18 for admission into inpatient mental health treatment and due process for the minor to object. That Act also allows for the minor to consent to treatment without the collateral consent of a parent and upon giving consent gives full control of the client record and access to those records to the patient/minor. It is essential that this be address as it constitutes a possible conflict with or duplication of other statues referenced in the proposed regulations. The proposed regulations should also provide regulatory guidance and compliance standards related to release and control of records related to the Federal Educational Rights and Protection Act (FERPA). Since nearly all of the children governed by these regulations are also students and served under public education statues it is essential that the department, in collaboration with the Department of Education develop and include regulatory guidance related to client health records that are requested or released by the RTF to the child's school.

23.31 Notification of rights, grievance procedures, and consent to treatment protections:
The proposed regulations do not provide information or guidance on Act 147 which amended the Minor's Health Care Consent Act to allow for parental consent on behalf of a minor up to age 18 for admission into inpatient mental health treatment and due process for the minor to object. That Act also allows for the parent to consent to admission without the consent of a minor child up to age 18 and for the minor to consent to treatment without the collateral consent of a parent. Act 147 also prescribes a process for petitioning the court when there is an objection to admission. The Mental Health Procedures Act only addresses voluntary and involuntary admission of minors age 14 and over to a psychiatric inpatient hospital level of care. It is essential that this be address as it constitutes a possible conflict with or duplication of other statues.

23.41 Family participating in the treatment process:
PCPA strongly endorses strategies that facilitate the involvement and participation of family members in the treatment process in RTF and other levels of care. Our members view family involvement as a vital part of RTF treatment and successful follow on service in the community treatment context. Family therapy and family oriented milieu models are supported by PCPA as component elements of the treatment program. The regulations do not address circumstances in which there are court ordered or non-court related custody issues and limitation or where the patient or custodial parent objects to the involvement of certain family members. An additional concern related to proposed regulations for family participation is that the costs related with family involvement are generally not "allowable costs" under federal Medicaid statutes. The regulations would be improved if they were less prescriptive and allowed the RTF and the family to develop a plan collaboratively or fully addressed any ambiguity or statutory conflicts related to this section.

23.54 Medical Director:
The current description of the Medial Director encompasses the scope of activity of the chief medical officer of the program as well as all the duties and responsibilities of an attending or staff psychiatrist. PCPA recommends that the Department create an addition paragraph and description for a staff or attending psychiatrist that, in collaboration with the Medial Director, can be engaged and deployed to carry out the core psychiatric over-sight and treatment activities consistent with the scope of licensure and training. PCPA recommends that the department make use of the American Academy of Child and Adolescent Psychiatry Policy Statement "Models for Minimum

Staffing Patterns for Hospitals Providing Acute Inpatient Treatment for Children and Adolescents with Psychiatric Illnesses" as a basis for the role of psychiatric staff. [note that while this document references "minimum staffing patterns" they are staffing patterns related to "acute inpatient treatment for children and adolescents" not the lesser RTF level of care.]

23.57 Mental Health Aid (Aide):
It is unclear as to the intended range of requisite qualifications for this position. E.g. can an individual who meets the educational qualifications for Mental Health Worker but does not have the required 1 year of child mental health experience be employed as a Mental Health Aide?

23.58 Staff ratios:
PCPA recommends that the department make use of the American Academy of Child and Adolescent Psychiatry Policy Statement "Models for Minimum Staffing Patterns for Hospitals Providing Acute Inpatient Treatment for Children and Adolescents with Psychiatric Illnesses" as a basis for the ratio of RTF staff. [note that while this document references "minimum staffing patterns" they are staffing patterns related to "acute inpatient treatment for children and adolescents" not the lesser RTF level of care. This paragraph takes the regulations beyond the scope of creating a safe and effective service within the Medicaid program.

23.59 Primary contact:
PCPA agrees that the treatment team serving each patient should have an identified primary contact. However, the prescriptive, extensive and complex list of duties and responsibilities listed in the proposed regulations are unreasonable and preclude the ability of the RTF administration, the clinical director or medical director to effectively or efficiently organize and assign duties and responsibilities to the staff of the RTF. This paragraph takes the regulations beyond the scope of creating a safe and effective service within the Medicaid program. Further, many of the duties listed are unreasonably vague and so open to interpretation as to preclude the effective development of policies and procedures that would ensure clear and indisputable compliance with regulation. E.g. (2) participating in high fidelity wraparound [vague and lacks clarity for regulatory compliance]; (3) promoting resiliency through risk reduction and asset building [vague and lacks clarity for regulatory compliance and invites conflict between provider agency and regulator]. While these are concepts that PCPA supports, they are note appropriate elements of regulations.

23.60 Family advocacy:
PCPA supports the concept of having a family advocate involved in RTF services and working to support the role of the family and service improvement. RTF providers have noted that it may be a conflict of interest for the family advocate to be employed by the RTF. It has also been noted that in order to comply with federal and state wage and hour regulations the cost of this position will need to reflect on-site and on-call costs in order to cover the responsibilities prescribed in the proposed regulations. It is not clear that this position represents an allowable cost under Medicaid cost regulations or that it has been fully reflected in the department's contention that this program addition along with others will be cost neutral.
23.62 Staff training:
PCPA supports strategies that expand and improve the skills of RTF staff. Of concern is the cost impact on the agency and therefore on the Medicaid program related to the cost of training and the cost of staff replacements and over-time related to training requirements.

23.62 (c) on-going training (5) A total of 20 hours of training in the following:
It is ambiguous and unclear whether the regulation requires all 18 training topics to be covered in one or more years in the 20 hours stated. It is clearly unreasonable to cover the 18 topics in an

effective or useful manner in a 20 hour period stated in the regulation. [vague and lacks clarity for regulatory compliance and invites conflict between provider agency and regulator]

23.143 Child health examination:
PCPA strongly supports timely and comprehensive medical examination and services for children. However, the current lack of physicians, especially pediatricians, who participate in the Medicaid program and who are able to schedule and conduct a health examination within 3 days makes the regulation unreasonable and beyond the compliance capability of the RTF. PCPA recommends an increase in the timeframe for compliance or a Medicaid regulation change that would compel a physician participating in the Medicaid program to give preferential service in scheduling and conduction the required examination and follow up health care services. Failure to address this issue may result in admission delays impacting psychiatric inpatient program or create a health and safety risk related to delays in admission related to health examinations being required prior to RTF admission.

23.147 Use of tobacco (b)" use of possession of tobacco products by staff is prohibited in the RTF and during transportation provided by the RTF:"
While the use of a tobacco product can be observed and enforced as a matter of RTF policy, it is not reasonable to require the RTF to be accountable for the "possession" of a tobacco product in the absence of its use. PCPA recommends the deletion of the work "possession" from this paragraph.

23.171 Safe transportation: This section fails to address or include the regulatory requirements of the Department of Transportation regarding vehicles used to transport students. While an RTF client is not technically a student, by virtue of their age, school law and definitions applied to the transportation of students . It is essential that this be address as it constitutes a possible conflict with or duplication of other statues.

23.183 Use of prescription medication (i):
PCPA supports clinical and medical practice that relies on patient/family education and voluntary and informed treatment including the use of medication. This regulation preempts the scope of licensure of the prescribing physician who is medically and legally responsible for admission, treatment and discharge. It is essential that this be address as it constitutes a possible conflict with or duplication of other statues. It is also reasonable to expect that "negative consequences" such as clinical deterioration, dangerous behaviors and other health and safety consequences of not taking medication may occur. It is also reasonable to expect that such clinical, physical or behavior deterioration may lead to discharge to a more intensive level of care. While the philosophical foundation and practices (paragraph j) for avoiding threats, consequences and discharge may be laudable, the inclusion of this paragraph in regulation is likely in conflict with statutes and/or regulation related to medial licensure, medical liability and the goal of good clinical care.

23.188 Medication self administration:
PCPA recommends that this section be revised to reflect the growing use of medication delivery systems ("patches" inhalers, eye drops, etc.) that may be considered by a physician or other health care provider to be appropriately "self administered" based on medical condition, safety, age and ability of the patient.

23.205 Emergency safety intervention (f) order for use (2) (i):
This paragraph makes reference to the child's "treatment team physician." The regulations do not include a definition or a description of either a "treatment team" or a "treatment team physician."

The lack of descriptions and definitions for treatment team, treatment team physician and the scope of responsibility for the Medical Director will create compliance issues of clarity and implementation.

23.221 Description of services (b) (10):
The regulatory requirement of an RTF policy and procedure related to" staff filing legal charges against a child" may be within the authority of the department and the RTF, the full enforcement of such a policy or action taken with a staff person who does not comply with such policy may be a violation of the employees civil rights. It is essential that this be addressed as it constitutes a possible conflict with other statues.

23.222 Admission process:
It is essential that the completion of pre-admission interviews and evaluations be included as a service procedure that is covered and compensated and required as an included and contracted service in the Medicaid and MA HealthChoices program. PCPA fully supports the value and role of the preadmission service to the child and family but it is critical that this be included as a specific and purchased service.

23.223 Development of the ISP (d) (1):
Reference is made here to the treatment team, team physician with regard to the team composition in relation (only) to the ISP. PCPA recommends that the definition and/or description of the treatment team and its membership be reflected in the "Staffing" section 23.51-23.62 of the regulations and that care be given to insure consistency, uniformity and clarity in the description and use of staff position, role and responsibly.

23.243 Content of child records (14) Education records: This regulation should be clarified so as to avoid any conflict between federal HIPAA and federal regulations (FERPA) governing the control, access and release of education records.

23.292 Participation requirement for an out of state RTF:
As currently stated the regulations for participation for an out of state RTF do not require out of state programs to fulfill all of the service obligation of bed and unit size limits, staff cost and other fiscal constraints placed upon Pennsylvania RTF providers. This will place RTF providers located and licensed in Pennsylvania at a financial and competitive disadvantage.

23.303 Bed Occupancy(a) (1) Minimum occupancy rate:
The limitation on facilities of "4 units of 12 beds each for a total of 48 beds" is arbitrary, beyond the stated scope of the regulatory process "to codify minimum licensing and program standards, requirements for participation in the Medical Assistance Program." The use of certified beds rather than staffed beds to calculate the per diem rate is not a useful or reasonable basis for a per diem cost calculation, may be inconsistent with common inpatient business practice in Medicaid and is likely to create a significant adverse impact. The calculation should be based on *prior year actual occupancy of staffed beds*. Staffed beds to more accurately reflect the cost related to capacity and care than does certified beds.

23.306 (b):
Costs, limitation and service excluded from RTF per diem rate
The limitation of administrative costs in excess of 13% does not support the increasing level of administrative complexity related to technology, regulatory compliance, accreditation and other

expanding administrative costs. This will place RTF programs at an economic disadvantage in comparison with other in-state hospital services and out of state RTF programs.

23.306 (i) (ix) exclusion of costs relate to meals for visitor, (xxiv) transportation and living costs associated with on-site family visits:
It is fiscally unreasonable for the department to require by regulation program elements that will incur specific costs that are not allowable for establishing the per diem rate. These conflicting regulations preclude reasonable compliance and/or constitute an unreasonable adverse economic burden on either the RTF or the family or other government agency (county) that may be charged for these non-Medicaid services.

23.307 General payment policy (c) payment is not made for (b)(v) therapeutic leave:
The department promotes and may require therapeutic leave as an element of treatment and discharge planning, while simultaneously excluding payment for these days. This has a significant negative impact on treatment, safety related to gauging discharge readiness and family and community engagement in post RTF treatment. This regulation also creates an adverse economic impact on the RTF.

PCPA appreciates the opportunity to provide comments, concerns and recommendations that reflect the perspective of our members from across the state. We hope that our input will be useful to the Department in the on-going process of developing final regulations. Questions and the response to these and all public comments should be directed to Connell O'Brien, Policy Specialist at Connell@parpoviders.org and at the address and phone number included in this document.