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Comments by Silver Springs - Martin Luther School

On the proposed Residential Treatment Regulations number 4-522

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Executive Summary

We are pleased to comment on these proposed regulations. We support many of the ideas contained in these proposed regulations, especially those that increase family involvement and that allow hiring psychiatrists as employees with the cost of their employment fully allowable. We support the full funding of all regulatory expectations. The current system has produced programs at risk of closure and others with large deficits; deficits that they will not be able to sustain going forward.

The fiscal impact of these regulations will be significant. These regulations will **not** be cost neutral. Our current Residential Treatment Program's projected deficit for the year ending June 30, 2011, is $787,000. This is because the per diem set by the Office of Medical Assistance does not cover costs and the Managed Care Organizations have rejected our requests for cost-based reinbursment. These proposed regulations require **additional staffing, which will increase costs**. The Mental Health Professional as required by these new regulations will **add $419,000** to the existing funding gap, meaning **$1,206,000** would need to be funded on top of our current charge for these services.

The diagnostic groups we serve include children who have experienced significant trauma and frequently are in the custody of Children & Youth. Where they will go after treatment (permanence) is often an issue. Permanancy issues frequently contribute to longer lengths of stay, which increase the **fiscal impact**.

The suggestion that shorter Residential Treatment lengths of stay will hold costs down is **not fiscally sound**.

Regulations should set the base for acceptable levels of service. These regulations micromanage services. They define tasks to be performed by mental health professionals that are not **feasible or reasonable, and will increase costs** that do not assure added quality.

There is no evidence to show that limiting the size of a residential treatment program will improve quality. Silver Springs has operated a 72-bed Residential Treatment program in Plymouth Meeting since 1973 that consistently has produced positive outcomes for the majority of children served. **The significantly decreased maximum census, as proposed in these regulations, also will increase costs**.

The regulations related to funding residential treatment raise serious questions about the **reasonableness of the requirements**. For example, the assumptions made as to how providers are to apply for and utilize each child's food stamps is an unrealistic expectation that also will **increase expenses.**

Specific comments in Response to the Proposed Residential Treatment Regulations

In the **Regulatory Analysis Form,** OMHSAS responds to specific questions. We would like to comment on some of these responses as well. Our comments are in blue.

(14) If scientific data, studies, references are used to justify this regulation, please submit material with the regulatory package. Please provide full citation and/or links to internet source.

The Department Wrote:

There is extensive evidence in the research literature which supports the requirements of these regulations in such areas as clinical standards, family involvement, and staffing requirements for RTFs, Sources include:

White Paper: Community Alternatives to Psychiatric Residential Treatment Facility Services, for the Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services, by Mercer Government Human Services Consulting (Mercer), a part of Mercer Health and Benefits LLC, April 4, 2008.

Our Comment:

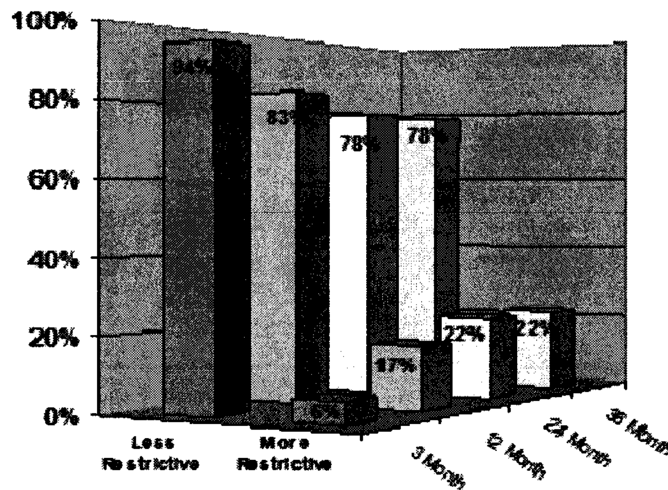
The white paper cited by the Department did not include interviews of or comments by providers of residential treatment services to younger trauma-involved children. If they had solicited this input, we would have been able to share the positive successes documented through the outcomes studies done at Silver Springs - Martin Luther School.

In 2001, Silver Springs began conducting an aftercare survey to track the progress of children who were discharged to a less restrictive setting at four different points in time: 3 months, 12 months, 24 months and 36 months post-discharge. Please contact Silver Springs if you are interested in receiving a copy of this study tool. The intent of the study is to look at whether children are "At Home, In School, and Out of Trouble."

"At Home"

Our surveys indicate that, after discharge from residential treatment, most children in this study are living in a Less Restrictive Setting at the time of the follow-up interviews. Of the families interviewed at each interval, over 78% indicated that the child was in a less restrictive setting. **In fact, even three years after leaving Silver Springs, 78% of the families reported that the child was living in a less restrictive setting.**

Follow-Up on Children Who Were Discharged to a Less Restrictive Setting - Where Children Are Up to 3 Years Post-Discharge



The aftercare surveys reveal that 69% of the children received <u>all</u> of the recommended behavioral healthcare services within one month of discharge from the RTF. **Ninety-two percent (92%) of the children received some type of behavioral healthcare service within a month of discharge**. Though for some of these children, one or more of the services were never received and/or there was a significant delay in service delivery.

Additionally, we cite the white paper developed by Magellan Health Services, "Perspectives on Residential and Community Based Treatment for Youth and Families," by the Magellan Health Services Children's Services Task Force.

http://magellanhealth.com/media/2718/CommunityResidentialTreatment_White_Paper.pdf

In this document referring to their research on residential treatment, Magellan writes:

> *"Because a treatment modality is not an evidence-based practice does not mean it won't be beneficial for some individuals. Residential treatment may be effective in certain circumstances. For example, Lyons, Terry, Martinovich, Peterson & Bouska (2001) confirm differential outcomes among youth in residence, and suggest that "residential treatment may be somewhat more effective with PTSD and emotional disorders rather than ADHD and behavioral disorders"(p.343). According to the research, youth often exhibit improvement for high-risk behaviors, such as suicidal ideation, self-mutilation and aggression towards people in residential treatment settings. Similarly, children and adolescents who cannot be safely treated in a community setting (e.g., those who set fires or repeatedly sexually offend), are usually better treated in a residential treatment setting (Mercer, 2008). Because every child has unique issue and needs, one has to determine what is in the best interest of each individual before making treatment decisions."*

This population, and particularly children who have post-traumatic stress diagnoses and have experienced significant trauma in their lives, may need longer lengths of stay to help them improve clinically and reduce the symptomatology that led to the need for residential treatment. Therefore, these regulations will **not be cost neutral** in that some children will continue to need lengths of stay of nine months to a year.

In addition to the trauma issues that children present, there often are permanency issues to be addressed. For example, in abuse situations, involved family members who remain in the home delay or prevent the return of a child as that setting is no longer an appropriate resource.

The white paper cited by the Commonwealth did not take into consideration the child's presenting diagnosis and how residential treatment may be relevant and appropriate for some populations.

(15) Describe who and how many will be adversely affected by the regulation. How are they affected?

The Department Wrote:

. . . . Further, the MA rate-setting process will address the additional cost associated with the requirements. There are 82 non-accredited RTFs with the capacity to serve 772 children and 81 Accredited RTFs with the capacity to serve 2515 children. * 58 of the 82 non-accredited RTFs and 17 of the 81 accredited RTFs exceed the maximum number of units per Location.

Our Comment:

The above is inconsistent in terms of represented numbers above and below. 82 non-accredited + 81 accredited RTFs = 163 (above) OR 17 accredited + 82 non-accredited RTFs= 99 (under (2) below). The Department's **response needs to be clarified and understandable.**

(16) List the persons, groups or entities that will be required to comply with the regulation. Approximate the number of people who will be required to comply.

The Department Wrote:

(1) To be licensed as an RTF, facilities will need to comply with the licensure requirements.

(2) There are currently 17 accredited RTFs and 82 non-accredited RTFs in the Commonwealth

In the section on cost and impact analysis (17), the question asked is:

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

The Department Wrote:

Not applicable

Our Comment:

Obviously, there are **significant fiscal implications involved in compliance with these regulations**. As noted above, these regulations call for additional staffing, including a family advocate and *mental health professionals* (who, as defined in these regulations are Masters level employees, are more expensive and more difficult to recruit than Bachelors level mental health *workers*) to be hired as direct care staff at staff-to-client ratios defined in these regulations.

The regulations expect RTFs to hire a Medical Director, a position not required by The Joint Commission (TJC), one of the accrediting organizations. Psychiatrists are important members of the treatment team and are required by Federal regulation. However, Federal regulations do not require an organization to have a Medical Director per se.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required, Explain how the dollar estimates were derived.

The Department Wrote:

Not applicable

Our Comment:

These regulations provide for rate increases to cover the additional expectations required of providers. As noted above, the additional costs will result in an increase in per diem rates.

Providers are required to have a contract with each county in Pennsylvania that uses the provider's residential treatment services. County contracts will be required to increase the per diem rate that they pay when medical necessity (funded through the Managed Care Organizations) no longer exists and the child remains in residential treatment due to permanency issues. Although such a situation is unusual, it does occur and, when it does, will increase the cost to counties utilizing residential treatment under these new regulations.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

The Department Wrote:

No fiscal impact is anticipated as a result of these changes.

Our Comment:

There is an assumption that length of stay in a residential treatment facility will be reduced considerably by these regulations. This logic is questionable because there are so many factors involved in determining length of stay. Medical Necessity may still exist for a child as determined by the child's psychiatrist. If so,

the child would remain in the prescribed treatment program. **There would be a fiscal impact from these regulations.**

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

Our Comment:

We believe that the Department of Public Welfare, Office of Mental Health and Substance Abuse Services has inappropriately avoided determining the costs associated with these proposed regulations. What is the foundation for their assumption that lengths of stay will be reduced?

(21) Explain how the benefits of the regulation outweigh any cost and adverse effects.

The Department Wrote:

The increased costs incurred by an RTF to meet the enhanced staffing and training requirements may result in higher per diem rates for some RTFs, but the expected aggregate reduction in lengths of stay due to high quality behavioral health treatment is expected to offset the fiscal impact of the higher rates.

Our Comment:

As noted above, this is an uncertain assumption.

(22) Describe the communications with and input from the public and any advisory council/group in the development and drafting of the regulation. List the specific persons and/or groups who were involved.

The Department Wrote:

Stakeholders including children, families, advocates, providers, county and state government representatives, and medical directors of behavioral health managed care organizations have been meeting to establish clinical guidelines and program standards for RTFs for the past decade in workgroups, through draft documents, at forums and meetings with recommendations that have been considered in drafting the proposed regulations.

Our Comment:

To our knowledge and based on discussions within the Provider Associations, there has been no opportunity for provider input on these regulations, in their current form, for over a year.

(23) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

The Department Wrote:

The proposed regulation is needed to codify the minimum licensing and program standards, requirements for participation in the MA program and MA payment conditions.

Our Comment:

The regulations, as currently written, do not establish minimum licensing and program standards. Instead, some sections micromanage in great detail how services are to be provided. Organizations with demonstrated positive outcomes for children have established staffing patterns and staff job responsibilities that differ from what is written here. For example, Silver Springs - Martin Luther School uses Bachelors level Mental Health Workers as direct service providers within the milieu. Mental Health Workers implement aspects of the treatment plans that are designed to occur within the treatment milieu. Mental Health Professionals, as defined by these regulations, provide a different type of direct service. Using Mental Health Professionals at the levels required by **these regulations will add an unnecessary fiscal burden not needed for the provision of quality services.** In addition, there will be great difficulty **and premium salaries required** to find enough Masters level professionals willing to work the shifts defined by these regulations.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

The Department Wrote:

Some of the provisions regarding restraint are more stringent than federal standards for restraint in RTFs. Pennsylvania is one of 8 states with a ban on prone restraints in all child residential settings.

Our Comment:

The standard that reduces the number of children allowed in any unit (12 children) and the number of units at a facility (4 maximum) is more stringent than the Federal standards. Once again, reducing the maximum census has a direct **fiscal impact** on increasing per diem rates.

(25) How does this regulation compare with those of other states? How will this affect Pennsylvania's ability to compete with other states?

The Department Wrote:

The proposed rulemaking will not put Pennsylvania at a competitive disadvantage with other states or be a cause for health and human service providers or individuals to leave Pennsylvania. Other states have comparable regulations for their RTFs.

Our Comment:

For some populations, including older, more aggressive children, Pennsylvania is not competitive with other states. These regulations would continue that problem. A specific

example is the regulatory expectations of providers in Texas, who define the types of services they plan to provide to clients in their program descriptions. If the program description is acceptable to the state of Texas, they become approved providers. Why has Pennsylvania placed children in Texas? Is Texas better able to serve aggressive and difficult children because their program descriptions give greater latitude for intervention, which is more appropriate for that population?

(26) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

The Department Wrote:

The proposed regulation does not affect existing or proposed regulations of the Department or another state agency.

Our Comment:

Would not the Department of Health be affected in that it has been assigned the role of monitoring residential treatment facilities?

(28) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The Department Wrote:

The proposed rulemaking applies to RTFs providing behavioral health services to children under 21 and no special provisions have been developed for minorities, the elderly, small business, and farmers.

Our Comment:

Residential Treatment Facilities are an affected group and they will be affected significantly by these regulations. Allowing grandfathering regarding the size of the population served and units per location at existing residential facilities would mitigate the **fiscal impact of these regulations**.

The Department has stipulated that accreditation is required with one of the existing accrediting organizations. It would be helpful to grant agencies accredited by The Joint Commission (TJC) or another organization "deemed status," which would eliminate some of the ongoing program audits. **This should significantly reduce the fiscal costs associated with employing state workers**.

The Department Wrote:

"By codifying all requirements for RTFs in one chapter, the Department intends to eliminate multiple licensing and monitoring visits to each RTF, thereby enhancing the efficiency of Departmental operations while minimizing interruptions in RTF programs. By requiring accreditation and the

concomitant adherence to the standards established by the accrediting entities, in addition to compliance with the requirements set forth in this proposed rulemaking, the Department intends to enhance the quality of care provided in RTFs." (p.2)

Our Comment:

Allowing grandfathering related to the size of the population served and the number of residential units per location at existing residential facilities, and granting accredited agencies "deemed status," which would eliminate some of the ongoing program audits, would **significantly reduce the costs associated with employing state workers.**

The Department Wrote:

(p2) Section 23.14 (relating to maximum capacity) specifically provides for a maximum number of beds per unit and a maximum number of units per facility. RTFs that currently exceed the proposed maximums will have the opportunity to develop and implement a transition plan to reduce the number of beds.

Our Comment:

If maximum capacity remains as written, it will be important for rate setting to be consistent with the final occupancy levels at 85% of those levels. This level of funding should parallel any transition plan to avoid a negative financial impact on residential treatment facilities.

The Department Wrote:

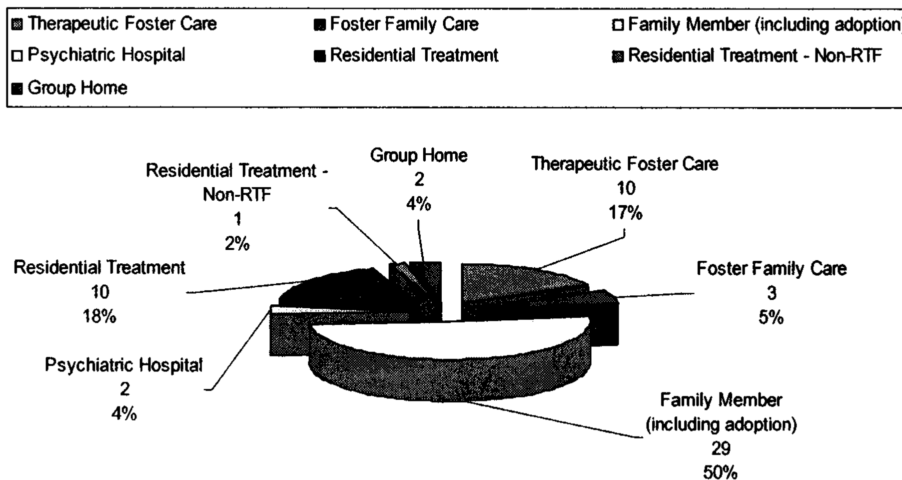
Fiscal Impact: The increased costs incurred by an RTF to meet the enhanced staffing and training requirements may result in higher per diem rates for some RTFs, but the expected aggregate reduction in lengths of stay due to high quality behavioral health treatment is expected to offset the fiscal impact of the higher rates. In addition, RTFs that are currently not accredited and choose to remain MA providers will incur the costs associated with accreditation. The Department will be able to build the cost of accreditation into the rates.

Our Comment:

This will not have a neutral fiscal impact on the costs to the Commonwealth. As mentioned previously, many factors influence length of stay. Further, the assumption here is a broad brush assertion that current practices at RTFs are not high quality. With nearly 80% of all Silver Springs – Martin Luther School children discharged to appropriate less-restrictive settings, high-quality behavioral health treatment is demonstrated. These regulations will increase costs with no guarantee of reduced lengths of stay.

WHERE RESIDENTIAL CHILDREN WENT AT DISCHARGE

Silver Springs uses a Restrictiveness of Living Environment Scale (ROLES) to monitor where children go when they leave the RTP. While not all children can return home directly from residential treatment, we are pleased that many of the children are discharged to less restrictive community settings. **In FY 2009-2010, 45 (78.9%) of the 57 children discharged went to less restrictive settings.** These settings included family members, foster family care, therapeutic foster family care and step-down programs. *In fact, 72% of the children were discharged into a family setting.* (Hawkins, R. P., Almeida, M. C., Fabry, B., & Reitz, A. L. (1992). A scale to measure restrictiveness of living environments for troubled children and youths. *Hospital and Community Psychiatry, 43*, 54-58.)



§23.17. Reportable incidents.

....(e) An RTF shall initiate an investigation of a reportable incident immediately following the identification of the incident.

As a point of clarification, the current practice and expectation of the Regional Office of the PA Department of Public Welfare is that an agency cannot begin an investigation prior to the Regional Office investigating the reportable incident. As written, this will change that practice.

§23.22. Applicable health and safety laws.

An RTF shall have a valid certificate or approval document from the appropriate State or Federal agency relating to health and safety protections for child required by another applicable law.

This expectation is unclear. We know we need appropriate certification from the Department of Health. However, we are unaware of any other health and safety issues require by law.

(f) A child has the right to visit with family at least once a week, at a time and location convenient for the family, the child and the RTF, as outlined in the family participation plan specified at §23.42(b)(2) (relating to documentation of efforts for family contact), unless visits are restricted by court order. This subsection does not restrict more frequent family visits.

While we agree with the intention and support children having weekly visits with their family when appropriate, it is problematic to have this ***always*** occur at a location convenient for the family. Current expectations are that the family is responsible for their own transportation when visiting their children. When there are financial concerns, we reimburse families for expenses related to visitation travel.

To ensure the safety of children and staff, we require that **two** staff travel with a child whenever they are transported. The expectation regarding convenient locations, combined with the staffing levels needed, will create additional costs and may unnecessarily influence a family's decision whether or not to transport or visit their child.

§23.54. Medical Director.

(a) There shall be one medical director who is responsible for overseeing the delivery of services and programs to children.

In residential treatment programs, psychiatrists are responsible for the treatment provided to children. Psychiatrists confirm medical necessity and sign off on the treatment plan developed for each child.

It is important to note that psychiatrists perform a **clinical role** and are **not administrative** in terms of their responsibilities. This is significant as it is important that psychiatrists be included in the clinical section of a Cost Report developed to fund this service rather than assigning them to the administrative costs center, which is capped at 13%. (Psychiatrists are the most expensive staff member in an RTF.)

We do not have a Medical Director. We have three child psychiatrists who are responsible for the clinical work noted above. The administration of the organization is responsible for oversight of the services and program. The regulatory expectation, as written, is inappropriate because it micromanages how a residential treatment facility is to function. The regulations do not allow for staff psychiatrists in addition to the Medical Director. One Medical Director for 48 children is not sufficient.

(b) The medical director shall be a board-certified or board-eligible psychiatrist with at least 2 years' experience in the delivery of behavioral health services to children.
(c) The medical director shall be responsible for the following duties: (1) Regular and ongoing contact with children and more frequent contact for a child on medication, ensuring at least 2 hours per week of psychiatric time for every 5 children.

As noted above, child psychiatrists are important members of the treatment team. Please note that TJC does not require a Medical Director.

Children may receive medication for physical issues in addition to psychotropic medication. The current language in the regulations should specify that a psychiatrist is responsible for psychotropic medication but not for other medications that may be prescribed by other physicians dealing with a child's physical health problems.

Given the expectations of managed care companies concerning authorizations and reauthorizations, two hours per week of psychiatric time for five children is ***insufficient*** to meet the needs of children in a residential treatment facility. Using the 48 census of these regulations, each child requires 1.25 hours of psychiatric time a week or 60 hours a week for 48 children.

(2) Ensuring a psychiatric face-to face visit with a child on psychotropic medication as deemed clinically appropriate, but not less frequently than every 30 days by the medical director or a psychiatrist working under the direction of the medical director.

Once again, requiring a psychiatrist to be under the direction of a Medical Director is micromanagement. The child psychiatrist/physician who chairs our Utilization Review Committee is responsible for the clinical supervision of our child psychiatrists. This person is Board certified and has over 30 years' experience providing clinical services to children in residential treatment and educational settings.

(7) Coordination and supervision of RTF staff on clinical and medical matters, including the prescription and monitoring of psychotropic and other medication.

Again, this is micromanagement. Psychiatrists are responsible for the psychotropic medication, and should be involved in and consulted around the possible adverse interaction between other prescribed medications. However, they are not responsible for the coordination and supervision of RTF staff on medical matters not related to clinical care issues.

§23.55- Clinical director.
§23.56 Mental health professional.
§23.57 Mental health worker and mental health aide.

While it is appropriate to set a standard for the education and experience that qualify individuals for these positions, the regulations should not dictate how supervision and responsibilities to provide quality residential treatment services should be assigned and provided to children and families. The program description submitted to and approved by the Commonwealth should be the standard to which an organization is held as related to specific job functions.
It is a residential treatment facility's responsibility to develop job descriptions and performance expectations associated with the services provided. This should involve the psychiatrist, mental health professional, mental health worker or aide, and the family advocate.

§ 23.58- Staff ratios.

(a) The staff to child ratio during awake hours must reflect the needs of the population being served. The minimum staff ratios in this chapter shall apply unless the Department's clinical consultants determine these minimum staff ratios are inadequate to meet the needs of the population being served as described in the RTF service description.
(b) Staff to child ratios.
(1) There shall be at least one mental health professional available either onsite or by telephone when a child is at the RTF.
(2) During awake hours, 1 mental health worker shall be present with every 4 children.
(3) A mental health worker or mental health aide who is counted in the worker to child ratio must be 21 years of age or older.

(4) For RTF's serving 6 or more children, whenever 6 or more children are present at the RTF, there shall be at least one mental health professional for every 6 children present at the RTF during awake hours.

(5) During sleep hours, 1 mental health worker or mental health aide shall be present with every 6 children.
(6) Staff may not sleep while being counted in the staff to child ratios.

This expectation is **unfeasible and unreasonable**. An overwhelming majority of Mental Health Workers have earned Bachelor's degrees in related fields. They are skilled in implementing the treatment plan in the milieu setting. **It is impractical and costly to hire Mental Health Professionals to work at the times and levels specified in these regulations.**

Mental Health Professionals provide treatment to children and families. There is a different skill set and training needed for mental health professionals providing treatment from the skill set necessary to be a mental health worker within the milieu. Many Bachelors level supervisory staff have more than 20 years' experience in providing treatment to children in the milieu setting. They should be able to supervise Mental Health Workers.

§23.59. Primary contact

(a) At the time of a child's admission, an RTF shall designate either a mental health professional or a mental health worker to be the child's primary contact during the child's stay at the RTF, to have primary responsibility for coordination of the child's care. The assignment of a primary contact will, at no time, preclude a parent, or when applicable, a guardian or custodian from communicating directly with the treating physician or other staff about the child.
(b) The primary contact's responsibilities include the following:
(1) Liaison activities for coordination and collaboration with other individuals and systems involved with the child, including the following:
(i) The family,
(ii) The behavioral health care manager at the appropriate behavioral health managed care organization,

(iii) The county intensive case manager,
(iv) The education system,
(v) The child welfare system, if applicable,
(vi) The juvenile justice system, if applicable.
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(2) Participation in the high-fidelity wraparound, if the child and family have a high-fidelity wraparound team.
(3) Promoting resiliency through risk reduction and asset-building strategies.
(4) Coordinating the child's aftercare plan with the community agencies that will provide services after discharge, the education system, natural supports, and the family prior to the child's return home by doing the following:
(i) Providing an aftercare agency with a comprehensive written discharge summary that includes information on the child's discharge diagnosis, treatment rendered during the RTF stay, treatment plans and the extent to which the child attained identified goals, and treatment team recommendations for the next level of care, following discharge. In addition, the written discharge summary must identify each psychotropic medication and dose, and describe the clinical rationale for each medication.
(ii) Ensuring that medications that the child will need until an appointment with the community based psychiatrist are prepared for discharge.
(iii) Assist the family in determining whether the prescribed medications are covered by MA. If a medication is not covered, the primary contact shall assist so that an appropriate substitute, which is covered, can be prescribed.
(c) The primary contact shall arrange for an onsite meeting with the parents and, when applicable, the guardians or custodians, within the first 7 days of the child's admission including day of admission and assist in developing the family participation plan as specified in §23.42(b)(2) (relating to documentation of efforts for family contact).

This is an example of the Department of Public Welfare not setting a minimum standard but rather prescribing a specific organizational structure and work assignments. The responsibilities listed in section §23.59., while appropriate, should be assigned by the leadership of the residential treatment facility. Regulations should not establish this type of detail but instead should identify issues and allow the organization to address them in a way that meets the organization's needs. DPW's expectation in this regulation is **unfeasible and unreasonable**.

§23.60. Family advocacy.

(a) For every 48 children, an RTF shall have on staff, or contract for the services of, a full-time equivalent family advocate. If an RTF serves fewer than 48 children, the RTF shall have on staff, or contract for the services of, a family advocate whose work hours are pro-rated according to the number of children in the RTF.
(b) The responsibilities of the family advocate include the following:
(1) Participating in quality improvement activities.

(2) Ensuring restraint reduction activities.
(3) Promoting the observance of children's rights.
(4) Reviewing of grievances.
(5) Ensuring availability to families and children as requested.
(6) Monitoring of general conditions.
(7) Facilitating family involvement plans.
(8) Participating in ISPT meetings at family request.
(9) Meeting with children regularly.

The intention in having a family advocate on staff is understandable. However, there is too much micromanagement in the designation of their tasks in these regulations.

§ 23.302 Income and offsets to allowable costs.

(6) If a child is eligible to participate in the Supplemental Nutrition Program (SNAP), it is the RTF's responsibility to contact the local county assistance office and utilize food stamps accordingly.

Organizations that operate a residential treatment facility should not be required to use food stamps to pay for the provision of meals for children. This is an **unreasonable expectation and will be an added expense as a new staff position will be needed to manage such an endeavor.**

(c) Payment is not made to an RTF for:

(v) Therapeutic leave,

Therapeutic leaves are an integral part of the residential treatment program and are prescribed by the psychiatrist. Therefore, they should be paid as part of the reimbursement to a residential treatment program. Currently, there are limitations on the number of annual therapeutic leave days that may be funded. However, funding is permitted and should be continued.

The costs incurred in providing all behavioral health treatment, including staff psychiatrist professional component of physician costs, and room and board are included in the per diem payment for RTF services and shall not be billed separately or in addition to the per diem payment rate by the RTF or any other entity with which the RTF may have an agreement to provide such services.

We are pleased that these regulations propose to allow psychiatrists to be included as staff members in residential treatment programs. Once again, a psychiatrist's job functions should be viewed as completely clinical in nature and not included in the 13% administrative cost.

(e) Administrative costs.

Administrative costs include costs incurred for a common or joint purpose and are associated with supportive activities that are necessary to maintain the direct effort involved in providing services to children. These costs are not readily assignable to a specific cost center or program unit.

The cost of the psychiatrist as a staff member is readily assignable to the clinical work performed in the residential treatment facility. There are no administrative responsibilities associated with this position.

(d) Compensation and staffing costs,

(a) Compensation for direct care, administrative, and support staff is allowable up to the combined prevailing Commonwealth salaries and benefits for functionally equivalent positions for staffing levels and positions specified in the current approved service description as described in § 23.221 (relating to description of services),

Commonwealth salary and benefits scales currently are not available to residential treatment providers. These need to be shared since the regulations create the expectation that provider salaries parallel the Commonwealth salaries and benefits scale. Since a residential per diem rate is negotiated with the Office of Medical Assistance Programs, why are residential treatment programs required to adhere to Commonwealth salary and benefits scales? Contrary to popular belief, many residential treatment programs are not state run but are operated by private providers.