Erhard, E. Shaye 2878 14-522-44

From: David Woodward [DWOODWAR@devereux.org]
Sent: Monday, November 22, 2010 10:46 PM
To: PW, RTFComments
Subject: Comments on Proposed PRTF Regs
Attachments: LTR Comments on PRTF Regulations.doc

Attached please find our comments on the proposed PRTF regulations.

Any questions or comments please do not hesitate to contact me directly. Thank you for your consideration.

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November 18, 2010

Shaye Erhard, OMHASAS
233 Beechmont Building
DGS Complex, P. O. box 2675
Harrisburg, Pa 17105-2675

RE: Public Comments on Proposed Rulemaking
Residential Treatment Facilities – Regulation No. 14-522

Dear Ms. Erhard:

Our comments to the proposed regulations are contained within the attached grid.

Section	Page #	Description
Preface	Item #13	Why are regulations necessary: "*To codify minimum licensing and program standards.*" These standards already exist as Federal Regulations – granted in several different locations, however, why incur State and provider expense to revise existing regulations? The cost of compliance for providers and the state will involve substantial direct and indirect costs.
	Item #15	It is argued that there will be "*benefits from these increases in standards that outweigh the costs.*" There is no data presented to support this assertion. The four studies cited produce no empirical case for change. • The regulations require accreditation – which will be costly to the programs and to the State as the cost of accreditation will be borne by the State within the rate structure for those programs not currently accredited • There are 82 non-accredited RTFs with capacity to serve 772 children that will be forced into payment requirements for the State or at the County level if they are not able to complete the accreditation process and receive Medicaid reimbursement • The new regulations appear to eliminate licensure for the non-PRTF programs that will eliminate funding for those programs unless they can be licensed. Who will pay for the care of those clients? • While there has been extensive public comment on previous proposed regulations – little of the comments appear to have been incorporated within subsequent drafts. • Many of the assumptions made by the framers appear to be based upon intuitive judgment and have not been subjected to actuarial methods of estimating costs.
	Item #16	Error – there are 81 accredited RTFs as opposed to "17"
	Item #19	It is argued there is no fiscal impact: • Increased costs will be born by the State and by County government for children in care that are not covered by MA regulation. • Additional costs of accounting & auditing, seeking & maintaining accreditation, and additional record keeping and mandatory reporting to State offices will add layers of cost to the programs. • Simultaneously the regulations impose an administrative cap prior to

		considering the increased expenses to implement the regulations.
	Item #21	"*Increased costs will be offset by high quality program*" – there is no current PA program model that proves this case and no "model" program has been referenced that at least suggests this assertion is accurate.
Summary	1	Regulations propose to replace all 3800 regulations – therefore, it appears that current regulatory environment for RTF and RTC programs disappears for all services not funded by the state of PA. If this occurs there will be no licensing structure for residential services funded by other sources of funding – which will force the State of Pennsylvania or County governments to absorb the cost of the programs or the programs will be eliminated. .
	7	Current regulations eliminate previous sections that addressed Secure standards for placement in the Commonwealth of Pennsylvania.
23.4	15	An RTF may submit a written request for a waiver – what conditions will be covered by the waiver?
23.14	17	*"An RTF shall not exceed 4 units of 12 beds each for a total of 48 beds."* • Does this describe an organizational unit for the RTF – therefore, each 48 bed grouping of beds is an RTF. • What empirical basis is there to limit the number of beds to this type of structure? • Current structures will be empty which cause financial losses for providers and for the state due to loss of efficiency • Can exiting facilities be grandfathered under the waiver process?
23.17	20	• A copy of the HCSIS report can be placed in the file - copies of all the investigative documentation should not be placed in the child's chart as it is risk management issue. • Regulations do not anticipate record storage by electronic systems.
	22	Requires copies of accident logs which violates risk management & discovery principles.
23.18	23	Why are incidents required to be kept in the business office vs. administrative offices of the RTF?
23.19	23	Checking accounts for client monies: • Need to be convenient to the program • Locating an interest bearing account without excessive fees given low balances will be difficult and expensive
23.32	30	• What is definition of "excessive medication"? • Child shall have seasonal clothing – however, the costs to provide such clothing are excluded from the per diem rate in section 23.306
23.57	37	Requires a minimum of one year of experience – what about a status of provisional employees to allow the attainment of 12 months under supervision or a mentoring arrangement? Otherwise there will be challenges to staffing programs to maintain required staffing ratios that will significantly increase the cost of the PRTF program.
23.58	39	Requiring one MHP per 6 children at RTF during "awake" hours – requires: • Each unit is 12 beds therefore there would have to be 2 MHPs for each "awake" shift • Therefore – 2 on 7a – 3p and 2 on 3p to 11p – 7 days a week • That is 1.4 x 4 = 5.6 FTEs for each 12 bed unit This requirement is excessive and does not appear to be based on any actuarial evidence.
23.61	41	Requires 15 min checks at all times – possible with the staffing ratios that are dictated, however, is there not a concern that the milieu is becoming a hospital and not a residential treatment program?
23.121	55	Only reference remaining to Secure residential
23.171	71	The requirements should read – requirements do not apply if transportation is provided **by** a source other than the RTF. The MHW:child ratio is 1:6 – does the driver count in the ratio other than when transporting one child to an

		appointment?
23.190	78	Metrics established for psychotropics • Why established – is there an evidence-based reason? • Why reporting regularly to the State – are results going to aggregated and reported regularly? • The information is already reported to the MCOs – why duplicate reporting?
23.201	79	Terms on page 90 of previous restraint guidelines addressed "briefly holding" as a clarification and were eliminated – why?
23.205	83	Added when Tx Team physician not available – orders by licensed staff – appears to be at odds with Department of Health and CMS regulations
	84	Mandating the Tx Team physician to be informed within 24 hours does not allow the Attending to take a vacation. Suggest wording: If provided by a covering physician; the Attending shall be notified upon their return.
	87	CMS regulations administered by the Department of Health already require monitoring on a 5 minute basis.
23.221	93	What is meant by staffing qualifications or ratio's that exceed the minimum?
23.222	95	The regulations appear to require each child to have an interview prior to admission. With this requirement, a mechanism to cover the costs of this process needs to be added to the regulations. Otherwise another unfunded mandate will be created.
23.226	102	Regulation requires "*assign sufficient staff to implement the ISP.*" Since this will vary with each treatment plan and be a variable cost to provide, how do the regulations propose to cover this expense in the cost report and rate negotiations?
23.243	109	Requires documentation of therapeutic leave – however, general statement of policy (C9b-v) state that payment will not be made for a Therapeutic Leave Day.
23.282	112	State will pay for elopements or "absence without authorization"
23.301	120	Will the state publish a list of prevailing Commonwealth salaries and benefits to assist programs calculating cost reports?
23.301	133	Costs incurred to transport the parent or guardian to a family therapy appt at the facility are allowable: • Transportation for the child is not allowable? • Staff transportation to the family's home for family therapy sessions with and without the child are not allowable? Determination of costs is to be made under the Medicare guidelines – that only address adults and are not specific to the needs of children and adolescents.
23.303	135	Use of an 85% occupancy level is used for calculations? Why? Establishes a floor
23.306	137	Why are administrative costs in excess of 13% not allowable? Why not 15% especially if you have limited the size of the program to 48 beds?
23.306	138 (xvi)	Why are barber and beautician services non-allowable for children in care over 30 days?
	139 (xxiv)	Transportation cost associated with on-site family visits are not allowable?
	141	SO – the required services of vision, dental, and hearing have to be covered in the ISP for a subcontractor to be reimbursed for providing the services.
	142	No arrangement has been made for therapeutic home visits that promote generalization of therapy and tests of therapeutic gains prior to actual discharge. With no home visit there is no way for the RTF to test whether the family and the child can make a successive transition on discharge. This has the potential to increase recidivism and therefore increase costs of care and possibly promote a "failure identity" for the child.
23.311	148	Audit report must be submitted by September 30 for the previous Fiscal Year – such turnaround is extremely expensive and often not possible within that time

		frame.
23.312	150	Use an adjustment factor – why not specify a market basket index used by the Federal government to be used?
	151	Please define or clarity the statement - "*staff psychiatrist professional component of physician costs*"
23.319	160	After rates are already established by an elaborate rate setting methodology employed by the Department – why allow separate rate setting processes with each of the MCOs? This is unnecessarily redundant, complex, time consuming, and expensive. Recommend that managed care organizations use the completed rate set by the Department.
3800.3	165	What is this chapter and how does it interface with the original chapter of regulations?? • Do the 3800 regulations disappear? And how about those programs that provide care currently under those regulations and fund placements through non-MA sources? • Are the 5310 regulations applied to these regulations?

Thank you for the ability to comment on the proposed regulations. If we can provide additional clarification or amplification of our comments please do not hesitate to contact me directly at 484.595.6708 or at **dwoodwar@devereux.org**.

Sincerely,

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