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Erhard, E. Shaye

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BUREAU OF CHILD

From: PCCYFS Harrisburg Office [hbgoffice@pccyfs.org]
Sent: Monday, November 22, 2010 6:14 PM
To: PW, RTFComments
Subject: PCCYFS Comments on Proposed RTF Regs
Attachments: PCCYFS Comments on Proposed RTF Regs 11 22 10.pdf

Importance: High

Attached please find comments on the proposed RTF regulations as compiled by PCCYFS based on input offered by our RTF provider members across the Commonwealth. Thank you for the opportunity to share concerns, ideas and questions.

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IRRC
2010 NOV 29 P 3:07

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RECEIVED
IRRC

2010 NOV 29 P 3:07

Date: November 22, 2010

To: Shaye Erhard
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P.O. Box 2675
Harrisburg PA 17105-2675

Emailed to ra-rtfcomments@state.pa.us

From: Bernadette M. Bianchi, LSW, Executive Director
Pennsylvania Council of Children, Youth and Family Services
2040 Linglestown Road suite 109
Harrisburg PA 17110

RE: Regulation No. 14-522
Proposed Regulations for Residential Treatment Facilities

On behalf of the many Residential Treatment Facility providers who are members of the Pennsylvania Council of Children, Youth and Family Services (PCCYFS), we are submitting comments on the Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS) proposed rulemaking for Residential Treatment Facilities (RTFs). We have encouraged RTF providers to also submit comments individually. The following pages address items listed on the Regulatory Analysis Form as filed with the Independent Regulatory Commission. Comments on the proposed regulatory chapter have been incorporated into the text of the narrative for ease in reference.

Please note that while there are a wide variety of concerns noted and areas where additional clarification is needed, there is appreciation of the efforts of OMHSAS to compile all relevant regulatory requirements governing RTFs into one chapter for ease in reference, eliminating the need for cross-referencing between interim guidelines, bulletins and regulations. And while there may be strong disagreement as to the process to be used to achieve best practice for children and youth in need of this level of intervention, there is agreement that the focus of efforts must be directed to enhancing the quality of care provided, supporting sustainability of the gains made once a child/youth is discharged through enhanced transition/discharge planning and ensuring that interventions are cost effective. Reduction of the number of licensing and monitoring visits to each RTF would be a welcome change and result is a far better use of resources.

We appreciate the opportunity to provide comment on behalf of RTF providers who are part of the affected community and remain available for further discussion regarding the proposed Chapter 23 as published.

General Comments - Regulatory Analysis Form
In response to information presented in Section I: Profile

(10) The OMHSAS Children's Advisory Committee is identified as the conduit for continual review of the regulations. It is noted that the Advisory Committee will conduct an annual review to consider recommendations by stakeholders and revise as needed.

The OMHSAS Children's Advisory Committee meets five times a year. While the intent of OMHSAS to proceed toward development of this proposed chapter was referenced in meetings, the Committee was never provided with a revised draft version, never formally notified of the date of publication in the Pennsylvania Bulletin, nor given notice of the availability of the of the document until the November 4, 2010 meeting.

This late notification restricted coordination of comments and limited opportunity for input since many committee members first heard of the status of this Chapter almost 2 weeks into the comment period. While a status update and notice of publication was included in the November 4, 2010 agenda, there was no time allotted for a detailed presentation. It would have been professionally courteous to provide advance notice of publication/content and availability on the IRRC website as well as the timeframe for the comment period to members of the OMHSAS Children's Advisory Committee to allow time for the Committee to respond in their recognized capacity. This missed opportunity for engagement of family members and youth is especially blatant given that OMHSAS is planning to utilize this Committee in the continuous review process. This new role for the Committee was never addressed in discussions with members nor has any precedent for this role been established.

In response to information presented in Section II: Statement of Need

(14) Concern is noted with the Mercer report as it was paid for by the Commonwealth and is not based on independent research. This white paper is viewed as being flawed in its selection of those interviewed, creating the assumptions addressed in the paper. They did not include interviews of providers of residential treatment services in Pennsylvania. The white paper did not take into consideration the diagnosis presented by a child and how residential treatment might be relevant and appropriate for some populations.

The findings in the 2008 Magellan Health Services Children's Services Task Force Report, "Perspectives on Residential and Community Based Treatment for Youth and Families" offer the following findings:

" 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 settings (Mercer, 2008). Because every child has a 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 posttraumatic stress diagnoses and who have experienced significant trauma in their lives may need longer lengths of stay to help them improve clinically and reduce the symptomatology that caused the need for residential treatment. Each child's situation is unique, negating the OMHSAS presentation that these regulations are cost neutral as some children may continue to need lengths of stay of nine months to a year. In addition to the trauma issues these children present, there are often permanency issues that must be addressed, especially when the family members who were involved in the abuse situation remain in the home and the return of a child to that setting is no longer an appropriate resource. Therefore, it seems inaccurate to assume that for this population and the length of stay will be reduced as suggested by OMHSAS.

The regulations are quite clear in the expectation that residential treatment facilities are to be run under a medical model. There must be a medical director of each program, even if all medical services are procured from community physicians), a psychiatrist must be the leader of the treatment team and there is a mandated role for nursing. Why the medical model? The Child Welfare League of American notes that residential group care is based on a non-medical model, and that this selection of a model was purposeful. Residential group care is a means to provide children with safe, nurturing, protective, therapeutic environments where educational, social, behavioral, and emotional needs can be met. Residential facilities were meant to be step-down, less intense and non-medical ways of keeping children in or near their communities. CWLA notes that just as in private families, physicians are not part of the daily interaction and behavior management. Direct care staff are the primary care givers and have the day-to-day involvement with the children.

The desire to transition children to a less restrictive setting demands that there be resources allocated and support the development of appropriate, accessible and readily authorized services which are flexible and child specific. To date, there has been little attention paid to the development of accessible and sustainable community- based services as part of the necessary array of services to support gains made in RTF placements and to promote long tern stability and reduce recidivism.

In response to information presented in Section III: Cost and Impact Analysis

(17) Cost/savings associated with compliance as incurred by the RTF providers (regulated community) is identified as being "not applicable". This is not accurate as there are clearly significant costs associated with compliance that OMHSAS has not considered and/or acknowledged. The realities of these increased costs are of

significant concern to RTF providers as there has been no inclusion of providers in discussions between the Behavioral Health Managed Care Organizations (BH-MCOs) and OMHSAS to address the significant increases that will be incurred in compliance with the new Chapter. These concerns include but are not limited to:

The costs of preparing for, achieving and maintaining accreditation for those providers currently operating as non-accredited RTFs are considerable. Consultant fees to support preparation have been reported as high as $150,000 in addition to the accreditation fees. If a consultant it not used, the process requires a dedicated staff person to support the process resulting in costs related to their salary/benefits and reassignment of their usual responsibilities. Costs of accreditation vary primarily by size and complexity of the agency being surveyed and include:

- the actual cost of the agency survey
- the cost of meeting compliance standards, which may occur both pre-survey while the agency participates in a self-assessment process or in post-survey, and
- often burdensome processes, many without perceived value.

There are also additional infrastructure costs associated with achieving and maintaining accreditation including data systems, quality improvement protocols, personnel costs related to the performance improvement monitoring process and information technology costs and support for external review teams. While acknowledging the value of improved practice and organizational operations, accreditation is not without additional costs incurred.

- Limitations on the physical size and related capacity will have a direct impact on costs incurred by RTF providers. Physical renovations are one option that could result in increased building/occupancy expenses. Decreased capacity will also have a very real fiscal impact as administrative /overhead costs are reallocated. Decreased RTF facility size will result in decreased staffing complements resulting in increased costs for Unemployment Compensation (UC). As many providers are self insured, this becomes a long standing financial obligation. The same UC concern is related to staff layoffs resulting from the proposed elevated credentialing standards which will result in long-term experienced and proficient staff being terminated as they do not hold the newly required degrees.

- The regulated community will incur significant costs specific to compliance with the proposed staffing ratios, staffing structure and staff training requirements. While there has been presentation by OMHSAS of potential opportunity for providers to negotiate increased rates with the BH-MCOs, there has been no clarity offered as to the preparation of the BHMCOs to respond to the increased costs projected. The following examples illustrate the projected costs increases that will be incurred by providers.

Example 1 - Minimum staffing requirements in the proposed RTF regulations

Each RTF unit now has 11 youth. Currently, one master's degree level therapist conducts all of the therapy for the 11 youth. With the requirements of the new regulations, the RTF provider would have to cover 28 shifts per week given that there would need to be 2 master's level "MH professionals" on each shift to comply with the new one staff for each 6 youth ratio. Currently, the one master's level therapist works 5 shifts per week which leaves 23 shifts per week or 4.6 full time staff equivalents to be filled to comply with the elevated requirements.

Projected costs increases - 4.6 FTEs @ $55,000 equals $253,000 additional dollars per year or $23,000 per youth or a rate increase of $63.01 per day. The current rate is $ 233.86/day and this one regulatory requirement will increase the cost of the daily rate $298.85/day. If limited to a maximum of 48 RTF beds, the total increase just for this one regulatory requirement would be $1,103,935.20 for the 48 beds. This does not include any additional expenses other than the one staffing requirement. The family advocate alone will result in an additional cost of $40/50,000 plus.

Example 2 - Minimum staffing requirements in the proposed RTF regulations
Mental Health Professional required whenever six or more clients are present would result in hiring at least six master's level staff to meet this requirement. A difference in salary between MH Worker ($25,000 per year) and MH Professional ($38,000) is $13,000. Total extra cost would be $88,140 plus additional FICA/pension costs.

Six to 1 resident/staff ratio for overnight workers - RTF is presently staffed at 10 to 1. This new ratio requirement would cost $25,000 x 5.5 extra overnight workers x 30% benefits for a total additional cost of $178,750.

The requirement for a nurse to be on site on first two shifts would result in new hires of 1.5 nurses. At $60,000 per year for one nurse with benefits at 30%, the additional cost would be $117,000.

Example 3 - Non-payment for Therapeutic Leave

Based on 40 youth in treatment per year with one 24 hour visit every two weeks times a $291 per diem rate results in an annual loss $302,640.

Calculation of costs related to examples 2 and 3

$ 88,140 - extra MHW's
178,750 - overnight workers
117,000 - nurses
302,640 - therapeutic leave
$686,530 per year Total Cost

Based on 40 youth x 365 day = An increase of $47.02 per resident per day would be incurred

Example 4 - Staffing requirements in the proposed RTF regulations

Current vs. Projected Costs for 22 Residential Treatment Beds
This breakdown does not include any costs associated with administrative costs including but not limited to; agency vehicles, nursing support, case management, facility costs / utilities, resident activities, staff development, human resources, quality assurance, supervisors, etc... The following only addresses costs associated with direct care staff, Master's level staff, physician services, and proposed family advocate position. The proposed regulations would require an additional 8 full time master's level therapist positions, for a total of 11 positions in order to cover 56 shifts per week as outlined by the proposed regulations.

	Current Costs	Projected Costs
Master's level therapists	$106,500.00	$457,000.00
Physician	$ 62,400.00 (8 hours per week)	$156,000.00 (20 hours)
Direct Care Staff	$684,288.00 22 staff	$933,120.00 30 staff

This cost includes projected benefit costs but does not include overtime costs

Family Advocate		$30,000.00
	Total Costs	Total Costs
	$853,188.00	$1,576,120.00

Estimated cost difference associated with proposed regulations - $722,732.00

Current reimbursement rate - $249.00 per day
Agency fiscal budget based on 80% capacity
Yearly estimated revenue - $1,545,045.00

Estimated revenue compared to estimated costs of only above noted costs
$1,545,045.00 - $1,576,120.00 = A deficit of $ 31,075.00

Example 5 - Staffing and miscellaneous requirements in the proposed RTF regulations

Medical Director – Current .6 FTE psychiatrist would be increased to full time (if possible), with a resulting increase in costs from about $96,000 without benefits per year to about $160,000 per year plus about 20% benefits. Total increase in cost would be about $96,000 per year.

Mandated frequency of contact between psychiatrist and children - As noted above, the RTF currently use the services of a .6 FTE psychiatrist. Under the proposed regulations, the psychiatrist is both leader of the team, and he/she must spend at least 24 minutes each week with every child under his/her care, even if the child is not taking psychotropic medication. With a maximum of 48 children, this represents about 19.2 hours of direct client contact per week. With the regulatory expectation that the psychiatrist function as the leader of the treatment teams and the responsibility of the psychiatrist to monitor the medication of all clients, it is obvious that the expectations for the psychiatrist far exceed what can be accomplished in .6 FTE (or 24 hours per week). Further complicating matters is the fact that children cannot be routinely pulled out of school to meet with their psychiatrist. This could be considered a violation of their IEP. Thus, the psychiatrist is typically limited to meeting with the child in the after school hours. To accomplish the necessary visitations, medication reviews, and team leadership, the RTF provider anticipates that 2.0 FTE psychiatrists will be needed. One of these would have to function as the medical director. To the current .6 FTE psychiatrist, an additional 1.4 FTE psychiatrists would be needed (one of these could function as medical director, although a primary care physician to provide medical care is still needed). With benefits, the addition of a second full time psychiatrist is projected as an additional cost of approx. $192,000 per year.

Waking Hour Coverage by Professional Staff - Currently, 7 mental health clinicians are employed to provide therapy and some case management services to 70 youth in treatment. With 48 clients maximum, the proposed regulations would require 8 mental health clinicians, and that 8 mental health clinicians be available during all awake hours. To achieve 8 mental health clinicians during the 7-3 shift and 8 mental health clinicians on the 3-11 shift across all seven days will require a minimum of 17 FTE mental health clinicians, and this assumes creative flexible weekend scheduling. For the seven current Mental Health Clinicians who serve a total of 70 children, annual costs are approximately $268,800 ($32,000 plus 20% benefits). To pay the 17 Mental Clinicians who will only serve 48 clients, the annual costs will be approx. $652,800 ($32,000 plus 20% benefits). The net increase associated with serving fewer children would be approximately $384,000.

Supervision of Direct Care Staff by Mental Health Professionals – Currently, 4 Residential Managers supervise the activities of direct care staff. They are assisted in this process by a number of residential supervisors. The proposed regulations would require that these individuals be replaced by mental health professionals as none of the current group would currently qualify despite the high quality of services that they currently ensure. The employment of these individuals would have to be terminated, with the resultant unemployment costs assessed to the RTF provider. These costs would be approximately $40,000. They would be replaced by persons who meet the standards of mental health professional. Locating such individuals may be a significant task. Most clinicians do not find the role of residential supervision to be particularly rewarding. Anticipating that a premium salary will be needed to attract mental health professionals to this work schedule and responsibilities, hiring four mental health professionals to fill this role will cost

as much as $240,000 plus about 20% benefits. This would represent an increase of approximately $96,000 per year.

Mandated census reduction and impact of number of workers – Currently, approximately 125 FTE direct care positions (Resident Counselors) under the proposed regulations would be called Mental Health Workers. A reduction in census from 70 to 48 is a 31% reduction in staffing need, resulting in the termination of employment of 39 direct care staff (31%). This would result in UC costs of approx. $390,000.

Medication delivery only by nursing staff – One nurse is currently on staff but the RTF, relies on medication administration trained staff to administer medication to clients. There are currently four medication trained staff whose role is solely to administer medication. Their employment would have to be terminated, resulting in unemployment costs in the neighborhood of $40,000. To shift to only nurses administering medications would require hiring an additional 3.0 FTE nurses at an estimated cost of $180,000 per year ($50,000 plus 20% benefits).

Consent must be obtained by physician – The RTF Provider relies on the psychiatrist to contact the family to obtain initial consent for any new medication. Based on legal counsel direction, these consents are considered valid for one year, and updated annually by the mental health clinician, with the provision clearly expressed to the family that the psychiatrist is available for any questions. If this responsibility for updated consents if delegated to the psychiatrist, it is anticipated that approx. 100 additional consent calls per year would be required. Allowing for time to establish contact and discuss the medication with the family, it is prudent to estimate 30 minutes for this process. Additional costs incurred - approx. 50 additional hours of psychiatrist time per year, or about $4615 in annual costs.

Restraint meetings – The regulations require a series of post restraint meeting within 24 hours of all who were involved in a restraint. The regulations would require three such meetings. To estimate the costs associated with these additional meetings, a number of assumptions are identified. First, because all clients must be supervised, direct care staff cannot be taken from their supervisory responsibilities to attend this meeting. The meetings must be done on overtime. Second, someone in management will probably lead the meeting. Third, each meeting will last at least 30 minutes. Fourth, because many RTFs specialize in serving children/youth whose dangerous behaviors result in a high probability of restraint, there will be a fairly high number of these meetings. While the RTF has been successful in reducing the number of behaviors that require the use of restraint, the average is still approx. 100 restraints per month, resulting in an estimate of 300 additional meetings each month

Based on the above assumptions, over the course of a year the RTF will have to hold about 3600 post-restraint meetings. This will consume about 1800 hours. Four staff and one management staff will be involved in each of the meetings, and hourly overtime rates for direct care are about $16.50, and a non-overtime supervisory hourly rate is about $18.82. This suggests that each half hour meeting

will cost about $42.41. Across the year, these meetings will cost the RTF provider approx. $152,676

Monthly ISP Review – Per the regulations, ISP review frequency is increased from semi-annually to monthly. Thus, each child will have 12 meetings per year, rather than the 2 that are required by the current Chapter 3800 regulations. Assuming 48 residents and an additional 10 meetings per year per resident, this will be an additional 480 meetings per year for Crestwood. While the costs of these meetings in projections for the psychiatrists have been included, the estimate of costs associated with other mandated attendees includes: psychologist ($30/hour), Nurse ($30/hour), Direct Care staff on overtime ($16.50 per hour), Occupational therapist ($20/hour), Teacher ($20/hour), social worker ($20/hour). Excluding physicians, the projected hourly cost for an ISP meeting would be about $136.50. If each meeting lasts about one hour, and if the RTF provider incurs an additional 480 such meetings per year, the projected costs of this regulatory requirement will be approx. $65,520

Required participation in the ISP – The proposed regulations require the participation of both a psychiatric social worker and an occupational therapist in these ISP meetings. Neither is currently on staff. To give reasonable caseloads to each person of about 24, two psychiatric social workers and 2 occupational therapists would need to be hired. Assuming that both positions can be hired for about $35,000 plus 20% benefits, the total additional cost of these positions would be about $168,000 per year.

The projected additional annual costs described above are listed below:

- $ 288,000 – additional 1.4 FTE psychiatrists
- $ 384,000 – waking hour coverage by professional staff
- $ 96,000 - additional costs of Mental Health Professional Supervisors
- $ 180,000 - medication delivery by nurses only
- $ 4,615 - consent obtained by physicians only
- $ 152,676 - additional post restraint meetings
- $ 65,520 – Monthly ISP meetings
- $ 168,000 – additional required ISP membership

$1,338,811 – additional annual cost (adds $76.42 to per diem)

The projected one-time costs of $470,000 are listed below:

- $ 40,000 – unemployment costs for terminating managers
- $ 40,000 – unemployment costs for terminating medication technicians
- $390,000 – unemployment costs associated with terminating employees not needed to serve reduced population

Total of these annual (only) costs - $1,808,811. This represents at least an increase of more than $75 per day increase in the current cost per child/youth. It must be recognized that the RTF competes with other providers throughout the Middle Atlantic Region as the majority of referrals are from outside PA. To impose these additional costs limits the ability of the RTF provider to compete with agencies not operating within this outdated medical model and its associated higher costs.

Example 6 - Staffing requirements in the proposed RTF regulations

Based on interpretation of the proposed regulations, this would require 5+ mental health professionals per unit, or at least 20 MHPs for four units. This equates to a ratio of 1 MHP to 2 clients. This ratio seems excessive and will be very costly. It is estimated that the increase in required Mental Health Professionals will result in a minimum per diem increase of $59.93. it is questionable as to whether or not the RTF provider can even find the clinicians to fill these positions.

This amount combined with additional costs related to the mandated Family Advocate position and the increase in Mental Health Workers/Aides needed during sleep hours (estimated $15.27 per diem increase) indicates the need for a substantially greater RTF per diem than currently in place.

The Commonwealth proposes to offset these increased costs by reducing the length of stay for children/youth in the programs, however, no actuarial or utilization data has been shared with providers to support this. Clearly, the BH-MCOs are the gatekeepers for this process and can control costs through their authorization processes. How their ability to control costs will interface with determinations of medical necessity and the treatment needs of children/youth is a significant unknown variable in all these costs projections.

- While the value of family participation in the treatment of a child in an RTF is recognized and supported, the costs related to achieving a higher level of family involvement are not addressed, either in the narrative of the regulations or in the funding currently available. Limits on what can be covered by Medicaid dollars are clearly delineated in the regulations as proposed. These increased requirements for family therapy, support groups, assistance in transportation, weekly visitation and transportation, phone calls, etc., while professionally and therapeutically appropriate, are nor fundable by federal Medicaid dollars. Without a defined and stable source of supplementary dollars to support compliance with these new requirements, they are an unfunded mandate, placing the "regulated community" at an even greater financial risk.

- OMHSAS has not disclosed the data used as the basis of their presentation that there will not be any increased costs incurred by the regulated community of RTF providers. Affected providers have not been asked for costs projections related to any of the above referenced areas of concern, nor have there been any inclusionary forums with the accreditation entities regarding their costs.

- The alternative of non-accredited RTFs to transition to become CRRs is suggested, yet there is no evidence of projected capacity needs for this level of care or verification of the interest/projected utilization and willingness to contract for this level of care by the BHMCOs. The option to be licensed as a CRR has been frozen

for years and there has been no inclusionary discussions with providers are to renewed interest in this option. This again places the regulated community at great financial risk as they attempt to reconfigure operations to respond to these newly defined directives.

• OMHSAS has presented that although the increased cost to RTF providers to meet some of the higher expectations of staffing requirements may initially create an increase in the per diem rate, the reduction in length of stay due to higher quality behavioral health treatment will offset that impact.

We respectfully note that this statement is incorrect and a misrepresentation of the depth and scope of costs that will be incurred. Shorter lengths of stay and the related costs of youth turn-over, reduced occupancy related to turn-over days, larger numbers of youth served, higher costs related to the initial days of service and increased time committed to discharge and disposition planning will all increase, not reduce the costs of care and the per diems.

Successful long-term outcomes connected to RTFs will become even more dependent upon the availability and easy access for supportive services post discharge including but not limited to OP treatment, partial hospitalization and/or day treatment programming, in-home/aftercare supports and other family based supports. There are also numerous cross-systems challenges which must be addressed in the process of discharge planning that are not identified anywhere in these regulations. They involve a different type of discharge planning and coordination with community supports for children and families involved in child welfare and/or juvenile justice systems.

(21) The response offered by OMHSAS regarding increased costs which may result in a higher per diem refutes their response offered in question (17). Actuarial projections, utilization data, research supporting the proposed defined unit size and staffing patterns are absent from these new requirements. The financial risk incurred by RTF providers opting to continue offering this level of care is high. Given prior OMHSAS/DPW directives to modify program designs to access Medicaid funding which have fallen short – "MA realigned programs" (ICSI) and secure RTF utilization - cause providers to directly challenge DPW projections without supportive data and documentation of need.

It is important to remember that the non-accredited RTFs were a creation of the Commonwealth of PA and the Department of Public Welfare and that in 2005 under MA Realignment, later renamed the Integrated Children's Services Initiative (ICSI), the numbers of such facilities were increased. The clear direction from the Department of Public Welfare was that by virtue of a youth's arrest, trauma history and need for out of home placement, the youth met medical necessity for RTF level of care. BH-MCOs authorization for this level of service has not reflected this assumption.

(22) The presentation by OMHSAS is valid in that there has been discussion regarding clinical guidelines and program standards for the past several years. The missing piece of this presentation if that there has not been any response offered by OMHSAS relevant to the repeated concerns voiced by affected RTF providers specific to these proposed clinical guidelines and program standards. One directional communication from OMHSAS has not created a strong foundation of confidence. Supportive research, capacity projections and fiscal implications have not been openly or realistically addressed. Providers remain unaware of any consideration given to concerns previously submitted as numerous regulatory requirements remain the same in this published version as they were initially presented, despite direct concerns voiced by affected RTF providers.

(23) The response offered by OMHSAS in this section does not answer the question. What else was considered as an alternative to these regulatory provisions? Can OMHSA defend these proposed regulations as the least burdensome when they are intrusive into the business operations of RTF providers and micromanage day-to-day operations in a prescriptive manner without explanation, research or evidence that they are best practice and support positive clinical outcomes.

(24) There are other items included in the proposed regulation that are more stringent than federal requirements. These include:

- the unit size and facility size limits
- staffing requirements and ratios
- creation of the paid position of family advocate
- frequency of plan reviews

(25) RTFs in Pennsylvania frequently accept referrals from other states. These regulatory requirements exceed those in place in other jurisdictions and will limit the ability of the Pennsylvania RTF providers to compete with agencies not operating within this prescriptive and cost prohibitive model.

(26) There are questions raised by the affected regulated community as to how these proposed regulations will coordinate with other state agencies including but not limited to:

- DPW Office of Children Youth and Families – requirements to address permanency for dependent children and accountability/competency development for delinquent youth
- Department of Health – restraint reporting requirements
- PA Department of Education – Appropriateness of educational placements, IEP requirements, incident reporting and use of restraint and staffing patterns
- Disability Rights Network – incident reporting and investigations

(27) While rate setting policies proposed do address costs associated with compliance, there are not assurances offered that the BHMCOs will positively respond to the increases in rates which are projected by affected providers. OMHSAS has repeatedly indicated that such contract provisions and rate negotiations rest with counties and BHMCOs yet, increases in costs are directly related to the proposed OMHSAS requirements. Unanswered concerns include:

- Will the BH-MCOs be bound to the same rate setting? Many of the BH-MCOs are paying RTFs lower rates than the prevailing MA FFS rate.
- If these regulations are going to guide rate setting and the RTFs will incur significant costs to comply with them, they need to be reflected in BH-MCO contract requirements as well.

Transition to full Compliance

How will the Department handle the two-year transitional period between when the regulations will go into effect and when the rate setting process would likely catch up with the higher costs incurred in compliance? Assuming these regulations increase daily RTF costs by 20% or more, this is a financial burden RTFs could not absorb. Plus, they would never be made whole for that interim loss.

Imposition of a clinical model

Trauma informed care is a model that many providers have adopted, but it is not a universally held clinical approach. The decision regarding clinical models and clinical approaches are best left to professional clinicians and should not be codified. The commonwealth should not be in the business of attempting to mandate what constitutes best practice or required practice but rather should require professionals to comply with their professional ethics and use only treatments with empirical support. Room must be left for ethical, adequately trained professionals to choose models of treatment other than those based on trauma informed care.

Mandated Reduction in Size of Business

Residential Treatment Facilities provide a service, and the Commonwealth, through the BH-MCOs is one of many purchasers. This should not give the Commonwealth the authority to limit the size of the business operations. It would seem that a reasonable argument might be made that the Commonwealth's proposed actions constitute a restraint of free trade.

ANNEX A

TITLE 55. PUBLIC WELFARE

PART I. DEPARTMENT OF PUBLIC WELFARE

Subpart C. Licensing/Approval

Chapter 23. RESIDENTIAL TREATMENT FACILITIES

Subchapter A. GENERAL PROVISIONS

Subchapter B. LICENSURE/APPROVAL REQUIREMENTS

GENERAL REQUIREMENTS

23.21. Confidentiality of records.

23.22. Applicable health and safety laws.

CHILD RIGHTS

23.31. Notification of rights and grievance procedures.

23.32. Specific rights.

23.33. Prohibition against deprivation of rights.

23.34. Notification of RTF restraint policy.

FAMILY PARTICPATION

23.41. Family participation in the treatment process.

23.42. Documentation of efforts for family contact.

23.43. Space onsite for family visits.

23.44. Assistance with coordination of transportation for family contacts.

STAFFING

23.51. Child abuse and criminal history checks.

23.52. Staff hiring, retention and utilization.

23.53. RTF director.

23.54. Medical director.

23.55. Clinical director.

23.56. Mental health professional.

23.57. Mental health worker and mental health aide.

23.58. Staff ratios.

23.59. Primary contact.

23.60. Family advocacy.

23.61. Supervision.

23.62. Staff training.

PHYSICAL SITE

23.81 Physical accommodations and equipment.

23.82 Poisons.

23.83 Heat sources.

23.84. Sanitation.

23.85. Ventilation.

23.86. Lighting.

23.87. Surfaces.

23.88. Water.

23.89. Air temperature.

23.90. Communication system.

23.91. Emergency telephone numbers.

23.92. Handrails and railings.

23.94. Landings and stairs.

23.95. Furniture and equipment.

23.96. First aid supplies.

23.97. Elevators.

23.98. Indoor activity space.

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GENERAL PROVISIONS

Subchapter A.

§23.1. Purpose.

The purpose of this chapter is to establish minimum licensing and treatment standards, MA participation requirements and MA payment conditions for RTF's.

Comment:

One purpose of the proposed regulations is to establish minimum treatment standards. The establishment of treatment standards is typically a professional decision rather than a state function. There is concern that the regulatory establishment of treatment standards may have the unintended side effect of stifling/limiting the development or utilization of new treatment procedures

It would seem reasonable for the Commonwealth to require providers and professionals to comply with professionally defined standards of care. However, the imposition of Commonwealth defined standards of care negate newly

developed interventions going forward and are not based the judgment of professional clinicians.

Because regulations are not flexible documents, it is not appropriate to attempt to codify treatment standards of care.

§23.2. Applicability.

This chapter applies to RTF's that operate in the Commonwealth to serve children under 21 years of age with a diagnosed mental illness, or serious emotional or behavioral disorder, or a drug and alcohol diagnosis in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder.

§23.3. Definitions.

The following words and terms, when used in this chapter have the following meanings, unless the context clearly demonstrates a different meaning:

Active treatment- The implementation and supervision of interventions and services outlined in a treatment plan.

Antipsychotic medication- A powerful tranquilizer, such as the phenothiazines or butyrophenones, used especially to treat psychosis and believed to act by blocking dopamine nervous receptors.

Comment:

A definition of antipsychotic medication is listed. The definition presumes both a level of power and a mechanism of biological action that may limit the inclusiveness of the definition. A better approach might be to define an antipsychotic medication as any medication that the FDA has approved to be marketed for the treatment of psychosis.

ASD- Autism Spectrum Disorder

BMI- Body Mass Index.

CAO- County Assistance Office.

CASSP (Child and Adolescent Service System Program)- A philosophy of collaborative service delivery in which services that are rendered to children and their families are least restrictive and least intrusive, child centered, family focused, community based, multi-system and culturally competent.

CCYA- The County Children and Youth Agency.

Certified day- A day of care approved by the Department under this chapter.

Child- An individual under 21 years of age.

CMS (Centers for Medicare and Medicaid Services)- The agency of the United States Department of Health and Human Services that is responsible for administering the Medical Assistance Program.

Contracting agency- A public or private entity that has an agreement with an RTF to pay for services provided by the RTF.

Cost center- A group of services or employees, or both, or another unit or type of activity into which functions of a facility are divided for purposes of expense assignment and allocations.

CRNP- Certified Registered Nurse Practitioner.

Department- The Department of Public Welfare of the Commonwealth of Pennsylvania.

Day of care- Room, board, and professional behavioral health services calculated on a 24-hour day basis using a midnight census hour.

Drug used as a restraint- A drug that has the following characteristics:

(i) Is administered to manage a child's behavior in a way that reduces the risk to the safety of the child or others.

(ii) Has the temporary effect of restricting the child's freedom of movement.

(iii) Is not standard treatment for the child's medical or psychiatric condition.

(iv) A drug ordered by a licensed physician as part of ongoing medical treatment, or as pretreatment prior to a medical or dental examination or treatment, is not a drug used as a restraint.

Eligible recipient- An individual who has been determined eligible for MA benefits.

Emergency safety intervention- The use of an intervention, such as a restraint or seclusion, as an immediate response to an emergency safety situation.

Comment:

"Emergency Safety Interventions" are defined but "Restrictive Procedures" are not. "Restrictive procedures" should be included in the "Emergency Safety Intervention" definition.

Emergency safety situation- Unanticipated child behavior that places the child or others at serious risk of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Family- Birth, adoptive or foster parents; grandparents; other relatives; non-relatives identified by the child; and guardians or custodians, except child welfare agencies.

Family advocate- A family member of a child who is currently receiving services or has received services from a child-serving system including mental health,

intellectual disabilities, child welfare, juvenile justice, drug and alcohol, or special education.

Fire safety expert- A local fire department, fire protection engineer, Commonwealth-certified fire protection instructor, college instructor in fire science, county of Commonwealth fire school, volunteer trained and certified by a county or Commonwealth fire school, or an insurance company loss control representative.

Fiscal year- The period of time beginning July 1 and ending June 30 of the following year.

High Fidelity Wraparound- A team-based, collaborative process for developing and implementing individualized care plans for children with mental health challenges and their families. The therapeutic goals of High Fidelity Wraparound are to meet the needs prioritized by youth and family, improve their ability and confidence to manage their own services and supports, develop or strengthen their natural social support system over time, and integrate the work of all child serving systems and natural supports into one streamlined plan.

Hospital-reserved bed day- A day when the child is approved for and admitted to an acute care general hospital, a psychiatric or rehabilitation unit of an acute care general hospital, or a psychiatric or rehabilitation hospital and the child is expected to return to the RTF.

Intimate sexual contact- An act of an erotic nature involving unclothed physical contact.

Comment:

A definition of intimate sexual contact is provided, however, this vague guideline will create potential for a variety of interpretations.

ISP- Individual Service Plan.

ISPT- Interagency Service Planning Team.

JPO- Juvenile probation office.

LEA- Local Education Agency.

MA- Medical Assistance.

Manual restraint- The application of a physical hands-on technique without the use of a device, for the purposes of restraining the free movement of a child's body or portion of a child's body.

Mechanical restraint- A device attached or adjacent to a child's body that the child cannot easily remove that restricts the child's freedom of movement of the child's normal access to the child's body, which include handcuffs, anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, and similar devices.

MH/MR- Mental Health/Mental Retardation.

Minor- A child under 18 years of age.

Comment:
A minor is defined as a child under 18 years of age, but a child is under the age of 21. Section §23.2. Applicability, indicates that this chapter applies to RTFs that operate in the Commonwealth to serve children under 21 years of age. Is there clarity and distinction between the two different age criteria in application in the narrative?

Natural supports- A non-paid assistance, relationship, or interaction that allows a child to advance in the community in ways that correspond to the typical routines and social actions of other people and that enhance the child's relationships.

PA- Physician's Assistant

PRN- Pro Re Nata

Psychotropic medication- A medication, as defined by active ingredient, in one of the following drug classes: attention deficit hyperactivity disorder agents; antidepressants; antidyskinetic agents; antipsychotic agents; anxiolytic and sedative or hypnotic agents; mood stabilizers; and substance abuse agents.

Comment:

A definition of psychotropic medication is provided. It should be noted that some drugs that typically fall into other classifications are used by psychiatrists. The most frequently used such classification would be antiepileptic medications that are sometimes used for bipolar disorder.

Restraint- A manual restraint, mechanical restraint, or drug used as a restraint as defined in this section, which does not include briefly holding, without restricting free movement.

Comment:

The definition of restraint as provided is confusing. It says that a restraint does NOT include brief holding. Additional clarification is needed.

RN- Registered Nurse.

RTF -residential treatment facility- A non-hospital living setting in which behavioral health treatment is provided to one or more children with a diagnosed mental illness, or serious emotional behavioral disorders or a diagnosed substance abuse condition in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder.

Comment:

The definition of Residential Treatment Facility is so broad it could be interpreted to include every program currently licensed under the Chapter 3800 regulations. Additional clarification is needed.

Seclusion- Placing a child in a locked room, which includes a room with any type of door-locking device, such as a key lock, spring lock, bolt lock, food pressure lock or physically holding the door shut.

Serious injury- A significant impairment of the physical condition of a child as determined by qualified medical personnel, including, but not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs.

Serious occurrence- A child's death, a serious injury, or a child's suicide attempt.

Staff- Individuals employed directly or on a contract basis by an RTF.

Trauma-informed care- A philosophy with related intervention practices that recognizes the prevalence and consequences of maltreatment or childhood trauma, is committed to avoiding re-traumatization during treatment and care, and promotes resilience to enable the child to overcome the negative consequences of trauma and move forward in the child's development.

Comments:

A definition of Therapeutic leave as a "day of care" needs to be included or a process to remove therapeutic leave days from the denominator when calculating days of care needs to be included.

Therapeutic Leave - A planned period of absence from an accredited RTF directly related to the treatment of the individual's illness to assist in the transition back to the home/community, promote adaptation post discharge, and identify areas of strengths and weakness that need to be addressed in the treatment plan before discharge. For payment purposes, a day of therapeutic leave is 12 to 24 hours of continuous absence for therapeutic reasons without regard to the calendar day and may not be used as a reward or punishment.

"Time-out" should also be added to the definition section. This strategy is very often misunderstood in the field/misinterpreted by reviewers.

Need definition of a "unit". Need flexibility in definition of a unit. Can an alternative be fewer children per unit with more units?

Need clarity as to the definition of the physical structure of an RTF.

What makes 4 units of 12 beds the ideal? What is the evidence to support this configuration? Is there flexibility? If each unit has their own director; what is the definition?

How are drug and alcohol services to be addressed within this context of this Chapter? Are these regulations replacing how the RTF to respond to the D&A needs is? How will youth with co-occurring diagnosis be referred? How will the sets/sources of regs be coordinated - DOH and OMHSAS?

Definitions regarding treatment teams and the child's service plan are needed.

§23.4. Waivers.

(a) AN RTF may submit a written request for a waiver of any provision of this chapter, except as specified in subsection (b) on a form prescribed by the Department, and the Department may grant a waiver of one or more provisions of this chapter if the RTF demonstrates the following:

Comments:

While the bulk of the proposed regulations are specific and prescriptive, the provision for waivers is vague and does not indicate the specific circumstances under which a waiver would be considered. For example, there are circumstances under which staff who have completed a medication training approved by the Department are permitted to administer medications, otherwise a licensed medical professional must administer the medications (23.187). If an RTF requests a waiver to continue having staff who have completed a medication training approved by the Department administer medications under all circumstances because proven competency in medication administration does not put the health or safety of a child in jeopardy – would that waiver be granted? If the Department approves trained but unlicensed staff to administer medications in some circumstances (23.189), why not in all circumstances? What is the difference between staff who can administer medication in sleep hours vs. waking hours?

(1) A waiver will not jeopardize the health or safety of a child.

(2) The RTF has an alternative for providing an equivalent level of health, safety and emotional protection of the children.

(3) The children will benefit from the waiver of the requirement.

(b) The scope, definitions and applicability of this chapter may not be waived.

(c) The Department may grant a waiver unconditionally or subject to conditions that the RTF must meet, and a decision to grant a waiver will identify the time period for which the waiver shall be in effect, subject to the review specified in subsection (e).

(d) AN RTF shall notify affected children and their families of the Department's decision to grant or deny a request for a waiver and post both the waiver request and the Department's decision in a conspicuous and public place in the RTF.

(e) The Department will review its decision to grant a waiver annually and may revoke the waiver if the conditions of the waiver are not met.

Comment:

There should be consideration given to "grandfathering" provisions for both staff and facility structures. While respecting the Commonwealth's desire to improve practice, these changes should be instituted with respect for both the agencies and their staff who have heavily invested in providing RTF level of care and who demonstrate competence.

Timelines for implementation and compliance are a concern as are costs related to UC and recruitment.

GENERAL REQUIREMENTS

§23.11. Licensure or approval of facilities.

The requirements of Chapter 20 (relating to licensure or approval of facilities and agencies) shall be met.

§23.12. Inspections and certificates of compliance.

(a) AN RTF will be individually inspected at least once a year, including at least one onsite unannounced inspection, unless otherwise specified by statute.

Comments:

Does this section imply a minimum of two visits per year? Or is it presenting the potential of the annual inspection as the unannounced visit? If the annual review is unannounced, a valuable part of the process – interaction with agency and RTF administration and clinical staff - may be missed as they may not be available.

This presents an expectation of more licensing inspectors and the availability of provider staff with the related costs for these on-site visits.

Inspections from numerous sources exercising oversight of RTF programs tend to disrupt programming and services delivery and require increased staffing costs.

There also appears to be support to add consumer satisfaction teams and the BHMCOs to this process. What assurances for coordination are offered?

There is a need to recognize and accept accreditation as the basis for compliance. Accreditation, with its incurred costs, already requires a CQI process with clear monitoring expectations. It is time to consider deemed status in the Commonwealth if accreditation is required to operate as an RTF.

There is a need for consistency across the variety of individuals/entities involved in the licensing process. A licensing checklist/instrument to ensure consistent expectations, especially considering the number of philosophical practice statements included throughout the regulations, would support consistent application and interpretation. How items will be measured should be clearly communicated in written protocols in advance rather than during inspection/review.

If deemed status is not considered, the question of the true benefit to providers of becoming accredited must be addressed. It becomes only a mechanism, and an expensive one, to allow the Commonwealth to access Medicaid dollars for this level of intervention.

Will the actual number of annual site inspections (DOH, OMHSAS, BHMCO, county, etc.) be reduced? Coordination with JCAHO, COA and CARF should also be a priority.

Consideration should be given to an alternative schedule of licensing reviews for accredited, highly competent programs or deemed status. They should be subject to less frequent licensing.

Multiple compliance related site visits are disruptive and result in resources (staff time and attention) being redirected away from patient care.

(b) A separate certificate of compliance will be issued for each physical structure that qualifies for a certificate.

Comment:

What does "Physical Structure" mean? How will this be defined? This is new/different terminology.

(c) The RTF must post in a conspicuous and public place the current certificate of compliance and a copy of this chapter.

Comment:

A copy of "this chapter" must be publicly and conspicuously posted. This chapter is 186 pages long. A requirement that the RTF "must have a copy of this chapter readily available and accessible" would be more appropriate.

§23.13. Appeals.

(a) AN RTF may appeal the Department's licensure or approval action under 2 Pa.C.S. §§ 501-508 and 701-704 (related to the Administrative Agency Law) and 1Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure), except that the appeal shall be made by filing a petition within 30 days after service of notice of the action.

(b) Subsection (a) supersedes the appeal period of 1Pa. Code §35.20 (relating to appeals from actions of the staff).

§23.14. Maximum capacity.

(a) AN RTF shall not exceed 4 units of 12 beds each for a total of 48 beds.

Comment:

The State has not communicated to the providers the rationale for the 48 bed maximum capacity or the 12 bed unit mandate. If the State is assuming that smaller RTFs equate to better outcomes or improved quality of care, RTF providers argue that successful outcomes are a direct result of the quality of the program being delivered, not the size of the program.

Downsizing to 48 beds will result in lay-offs that will have a significant negative impact on our local community and will systematically deny access to our quality service to many young people who need our help.

If this proposed cap in instituted and the per diem rates do not make up for the lost revenue, the ability of providers to continue operations is questionable. How will the new per diem rates be calculated and how will the initial rate be set? Providers cannot operate an entire fiscal year with all of the additional costs being imposed upon them under the new regulations. An initial increased per diem will be needed by each RTF provider in advance of operating under the new RTF regulations. Providers cannot wait for a formal rate setting review (MA Cost Report/BFO Audit etc.) process to occur. What is the plan for the new per diem rate and how and when will it be determined?

Medicaid places no limits on building size. What is the clinical basis for this size configuration? What research has been reviewed to support this proposed configuration? What can the Commonwealth offer as justification for limiting facility operations? Have actuarial calculations been completed that project capacity needs? Wings or unit size?

Has consideration been given to the true fiscal impacts to smaller facilities in meeting these new proposed standards? The proposed requirements present significant challenges to maintaining smaller facilities in communities. These proposed practice standards appear to be contrary to the practice model stated in other discussions regarding accessible, close to family and child service options to support family involvement.

What will happen to the programs that currently exceed this size limitation? Will they be grandfathered? Or will they need to cut capacity/staffing even though there may be current utilization?

Is there any flexibility in this process based on locale/geographic need?

While the Commonwealth/BHMCOs can elect to not do business with larger providers, the authority to direct an independent business to downsize or lose their license is questioned?

Who will become responsible for the unemployment costs associated with such actions? Will the commonwealth indemnify individual providers for actions taken at their direction? Does the Department really want to lay off so many workers and lose jobs?

The alternative for non-accredited programs to become licensed as a CRR is challenged as this transition process will take time and has fiscal implications without assurance of need or willingness of the BHMCOs to utilize this level of care.

Base line costs are going to increase significantly. Managing this restructuring process will require staff and financial resources. New service descriptions will be required. What will be the process for timely review and approval?

(b) The maximum capacity specified on the certificate of compliance will be based on available bedroom square footage, the number of toilets and sinks, the needs of the population of children residing in the RTF, the RTF's staffing levels, the RTF's program components, and the treatment intensity of the RTF.

Comment:

The Commonwealth is to determine the maximum capacity of a program, but no information is given regarding what rules or formula will be followed in making such decisions. Capacity is usually a business decision typically left to the business owner.

While the Commonwealth, through the BH-MCOs, can elect to limit the amount of business they do with any entity, the authority of the Commonwealth to limit the size of a business is challenged.

This new Chapter of regulations does not set the terms for a new program/level of service going forward, but rather directs major reconfigurations of an existing service network without benefit of true capacity/need projections. The diminished use of RTF levels of care should not be based on the decision of diminished availability of the service that will be outcome of these regulatory restrictions.

(c) The maximum capacity specified on the certificate of compliance may not be exceeded and may be temporarily or permanently reduced if the Department determines that the physical plant, clinical programming, or needs of the population of children residing in the RTF requires that maximum capacity be reduced.

Comment:

This section indicates that the Department can reduce capacity if it decides that such action is required by the clinical programming. What standards will the Commonwealth use to support a such decisions? Who holds this vested knowledge of clinical programming within the Department?

Given the presumptive validity of professional judgment acknowledged by the Supreme Court in Romeo v. Youngberg, one would have to assume that only

another group of at least equally qualified professionals would be able to make such a decision.

Clear criteria must be developed and circulated regarding the justification and basis for reducing the capacity. The provider must have clarity as to steps necessary to alleviate the problems/address the issues. Without a clearly developed, written basis for this decision rendered by the Department, there is a corresponding absence of clear direction for the provider to develop a remedy.

§23.15. Fire safety approval.

(a) If a fire safety approval is required by State statute or regulations, a valid fire safety approval from the appropriate authority, listing the type of occupancy, is required prior to receiving a certificate of compliance under this chapter.

Comment:

Please define what/who is referenced as the 'appropriate authority'?

(b) If the fire safety approval is withdrawn or restricted, the RTF shall notify the appropriate Departmental regional office orally within 24 hours and in writing within 48 hours of the withdrawal or restriction with a plan for remedy or a plan for child relocation.

Comment:

Please define what/who is referenced as the 'Regional Office?

Is this action exempt from reporting requirements in HCSIS? Or does this present the expectation of duplicative reporting? Or will RTFs operating under this Chapter be exempt from HCSIS reporting requirements?

There are concerns regarding the potential for multiple reporting requirement and duplicative procedures throughout this proposed Chapter.

(c) If a building is structurally renovated or altered after the initial fire safety approval is issued, the RTF shall submit to the appropriate Departmental regional office within 2 weeks of the completed renovation, the new fire safety approval, or

written certification that a new fire safety approval is not required, from a fire safety authority.

§23.16. Child abuse.

(a) AN RTF shall immediately report suspected abuse of a child in accordance with 23 Pa.C.S. §§6301-6385 (relating to the Child Protective Services Law) and 55 Pa. Code Chapter 3490 (relating to child protective services).

Comment:

Suspected abuse of a child must be reported to ChildLine. A Child in this chapter is defined as a person up to the age of 21 years, but ChildLine only accepts reports on people up to the age of 18. Clarification is needed.

(b) If an allegation of child abuse involves staff, the RTF shall submit and implement a plan of supervision in accordance with 23 Pa.C.S. §6368 (relating to investigation of reports) and §3490.56 (relating to county investigation of suspected child abuse perpetrated by persons employed or supervised by child care services and residential facilities).

§23.17. Reportable incidents.

(a) A reportable incident is one of the following:

(1) A death of a child.

(2) A physical act by a child to attempt suicide.

Comment:

Please provide additional clarification of an attempt at suicide.

(3) An injury, trauma or illness of a child requiring inpatient treatment at a hospital.

(4) An injury, trauma or illness of a child requiring outpatient treatment at a hospital, not to include minor injuries, such as sprains or cuts.

(5) A violation of a child's rights specified in §23.32 (relating to specific rights).

(6) Intimate sexual contact or attempted sexual contact between children, consensual or otherwise.

Comment:

Attempted sexual contact between children is a reportable offense. Given that a child can be older than a minor, a situation in which two adults (i.e., over 18) kissing each other could be a reportable incident. Additional clarification is needed.

Additional clarification and examples of "attempted sexual contact" are needed.

(7) Sexual assault of a child.

(8) A child absence from the premises for 2 hours or more without the approval of staff, or for 30 minutes or more without the approval of staff, if the child may be in immediate jeopardy.

Comment:

A definition of "immediate jeopardy" is needed.

(9) Use of a drug as a restraint.

Comment:

Why is this being required as a reportable? This is prohibited in this proposed Chapter.

(10) Abuse or misuse of a child's funds.

(11) An outbreak of a serious communicable disease as defined in 28 Pa. Code §27.2 (relating to specific identified reportable diseases, infections and conditions).

(12) An incident requiring the services of the fire, police, or emergency management departments, except for false alarms.

(13) A condition which results in closure of the RTF.

(14) Emergency relocation of a child.

(15) Food poisoning of a child.

(16) Bankruptcy filed by the RTF.

(17) A prescription medication error.

General Comments:

Does the Department really want every medication error including late/missed dosage as a reportable incident? What will DPW do with all this detail?

Cost implications and increased paperwork to address reporting these details are concerns. Who within the Department will be charged with reviewing this information and what they will do with it?

There needs to be consistency with accrediting entities' definitions as well as with Medicaid and BH-MCO requirements to avoid duplication of effort and wasted resources.

Does this include all prescription meds or just psychotropic meds?

Will it be necessary to report near missed doses as errors? Do refusals need to be reported?

What is the reporting mechanism for non-HCSIS events? This data is not currently consistent with or required by the categories for HCSIS. Will the requirement for reporting through HCSIS be removed for facilities licensed under this new Chapter?

Medications errors/missed doses during home visits - will these need to be reported?

(18) A criminal conviction against the RTF, administrator or staff that occurs after the reporting on the criminal history checks under §23.51 (relating to child abuse and criminal history checks).

Comment:

The provider is now to be required to report any criminal convictions of staff. Is there an expectation of regular or routine criminal checks on all staff in addition

to those done at time of hire? How is a provider to know this whether an employee was convicted of a crime?

Please clarify if there is an expectation of more frequent criminal checks. If so, there must be consideration given to the increased costs of obtaining these ongoing background clearance checks.

Criminal convictions – what exactly is the scope of this expectation? Define "criminal"?

(b) AN RTF shall develop, and submit for Department approval, written policies and procedures, on the prevention, reporting, investigation and management of reportable incidents.

Comment:

Will the Department have available staff, who are well versed in the issues related to the various policies, and who can respond to this increase in workload/review of the variety of policies requiring Departmental review, allowing for this review to be completed in timely manner?

(c) AN RTF shall complete an initial written reportable incident report, in a format prescribed by the Department, and send it to the appropriate departmental regional office, the contracting agency, the Department of Health, the RTF's Family Advocate, and the Disability Rights Network no later than close of business the next business day. Staff must document in the child's record that the incident was reported and a copy of the report must be maintained in the child's record.

Comment:

Currently, practice dictates that incident reports are maintained in a file separate from the child's record. Is it now to be best practice to have these included in the individual child's file? Will they need to be included in both locations?

Given the scope of reportable incident and the required investigation process related to many, there are alleged incidents that prove to be unfounded. Again

practice has been to maintain a separate file of indicate reports rather than to merge these into the individual child's file. Can this option be considered?

Which prescribed format is to be used? BH-MCOs have own formats as does HCSIS. What is required by the Disability Rights Network? Duplication of effort should be avoided.

Some of the reportable incidents are not child specific. Is there an expectation that these general incidents would be included in the files of all children the facility?

Is there an expectation for incidents to be reported through the Commonwealth designated HCSIS system? Need to clarify connection with HCSIS if any, as well as consistency with other entities' reporting requirements.

Is there a role for the Family Advocate in informing the family?

The Dept. of Health is currently not notified, and is not included in releases signed at admission and annually. Who in the Dept. of Health is to be notified? For what purpose? Is there an expected response?

The Disability Rights Network is currently not notified, and is not included in releases signed at admission and annually. Who in the Disability Rights Network is to be notified? For what purpose? Is there an expected response?

Incident reports are typically kept in a separate file, especially if there is alleged abuse that is later unfounded. These regulations would require the incident reports be kept in the business office for 6 years, raising questions about management of clinical information in a business office and confidentiality of clinical information as well as alleged child abuse that may later be unfounded.

(d) AN RTF shall orally report to the appropriate Departmental regional office and the contracting agency within 12 hours of the following:

(1) A fire requiring the relocation of children.

(2) An unexpected death of a child.

(3) A child's unauthorized absence from the premises, if police have been notified.

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

Comment:

This section requires an investigation of every reportable incident report. Is there an expectation of a full investigation (with statements, interviews of all nearby staff, collection of evidence) of such relatively benign incidents as a child falling off a bicycle and cutting his/her leg?

The term investigation has a specific meaning to many providers, and it typically is a laborious process. Those investigators who have been certified by DPW as abuse investigators know that any investigation is a significant undertaking if the standards taught to certified investigators are to be followed. If this is the meaning of the proposed regulation, additional costs will be incurred.

This section requires a provider to initiate an investigation immediately following the identification of the incident. In cases of child (under 18) abuse, there is a prohibition of any investigatory action that might corrupt the investigation of the Office of Children, Youth and Families. Providers are not permitted to investigate until OCYF authorizes moving forward, and they have up to 60 days to complete their investigation. Similarly, when police are involved, the initiation of an investigation by a provider could corrupt the more important police investigation.

Additional clarification of this process is needed to ensure compliance with other statutory and procedural requirements.

(f) AN RTF shall submit a final written reportable incident report to the agencies specified in subsection (c) by no later than close of business the next business day following the conclusion of the investigation.

(g) If the final reportable incident report validates the occurrence of the alleged incident, the RTF shall notify, unless restricted by applicable confidentiality statutes, regulations or a court order, the affected child and other children who could be potentially harmed, and their family.

Comments:

What is the expectation in this reference - what should be included in this notification? Need to address and clarify under what situations this should occur.

Need clarification as to duty, how far would this communication is expected to extend, content etc.

Potential issues of confidentiality are identified. Confidentiality statutes and regulations restrict to whom information can be released.

This section – scope and intent - needs to be better defined.

Unintentional impact of family and youth finding being advised on staff reprimands/disciplinary actions and effects of relationships/interactions is a concern.

General risks to be identified; do parents and child advocates need to be notified with every incident?

How is "children who could be potentially harmed' defined when there is a reportable incident? If there is an accidental fall and break or if there is a medication error, must all other children be notified of the potential harm?

(h) A copy of a reportable incident report shall be maintained for 6 years in the business office of the RTF.

Comments:

Where and how must these records be kept?

Can it be an electronic copy?

Will HCSIS be used?

Why maintained in the business office? This could create a HIPAA issue.

(i) AN RTF shall notify the child's parent and, when applicable, the child's guardian or custodian, as soon as possible, and in no case later than 24 hours after a reportable incident relating to a specific child, unless restricted by applicable confidentiality statutes, regulations or a court order. AN RTF shall document in the child's record that the parent and, when applicable, the guardian or custodian, has been notified. The documentation must include the date and time of notification, the name of the staff providing notification, and actions taken subsequent to the event until the time of contact with the parent, guardian or custodian.

Comment:

How are incidents that occur outside the RTF in the community or school, to be investigated and reported?

(j) Reporting of deaths.

(1) In addition to the reporting requirements contained in this section, an RTF shall report the death of a child to the CMS regional office by no later than close of business the next business day after a child's death.

Comment:

Providers are required to notify the CMS regional office of the death of a child. Not every child in a Residential Treatment Facility will be funded through Medicaid funds. If the child is not funded by Medicaid, why would CMS need to be notified? Additional clarification is needed.

(2) An RTF shall document in the child's record that the death was reported to the CMS regional office.

(k) AN RTF shall notify the child's parent and, when applicable, the child's guardian or custodian of a child who has been restrained as soon as possible after the initiation of each emergency safety intervention.

Comment:

Every restraint to be reported even though restraints are not reportable incidents?

(l) Reporting of a serious occurrence.

(1) AN RTF must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated protection and advocacy system.

Comment:

Clear identification of the state entities as referenced in various sections throughout this proposed Chapter is requested to ensure compliance.

(2) Serious occurrences that must be reported include the following:

(i) The death of a child.

(ii) A serious injury as defined in this chapter.

(iii) An attempted suicide by a child.

Comment:

Clarification regarding gestures or acts as an "attempt" at suicide is needed as judgment will vary across professionals involved.

(3) Staff must report a serious occurrence involving a resident to both the Department and the State-designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include the following:

(i) Name of the child.

(ii) A description of the occurrence.

(iii) Name, street address and telephone number of the RTF.

Comment:

Clear identification of the state entities as referenced in various sections through this proposed Chapter is requested to ensure compliance.

(4) In the case of a minor, an RTF must notify the child's parent and, when applicable, legal guardian or custodian as soon as possible, and in no case later than 24 hours after the serious occurrence.

(5) An RTF must document in a child's record that the serious occurrence was reported to both the Department and the State-designated Protection

and Advocacy system, including the name of the person to whom the incident was report. A copy of the report must be maintained in a child's record, as well as in the incident and accident report logs kept by the facility.

Comment:

Multiple locations for documentation - This is duplication of effort.

What is an incident and accident report log?

§23.18. Recordable incidents.

AN RTF shall maintain for 6 years in the business office of the RTF, a record of the following:

Comment:

Why the business office? Does this mean agency administrative office?

Format of the records? Electronic?

(1) Seizures.

(2) Suicidal gestures.

(3) Incidents of staff or residents of the RTF intentionally striking or physically injuring a child.

Comment:

The use of the word "intentionally" should be deleted. Intent is unknown and philosophically a fuzzy construct.

If it is an incident involving a staff physically injuring a child, it would be reported to ChildLine and would be a reportable incident – this requirement will result in duplicative efforts.

(4) Property damage of more than $500.

Comment:

Property damage over $500 is considered a recordable incident. This property does not belong to the Commonwealth. The destruction of property not belonging to the Commonwealth should not be a regulatory issue.

Records are kept on destruction of property for other purposes such as for the sanctuary model, however, dollar amounts are different.

(5) Child absences from the premises without the approval of staff, that do not meet the definition of reportable incident in §23.17(a) (relating to reportable incidents).

(**6) Injuries, traumas and illnesses of children that do not meet the definition of reportable incident in §23.17(a) (relating to reportable incidents), which occur at the RTF or offsite.

Comment:

Examples of injuries, traumas fitting the above requirement are requested.

(7) Emergency safety situations, the emergency safety interventions used, and their outcomes.

Comment:

Double reporting; inconsistency HCSIS reportable vs. recordable

Instead of information being kept in the in the business office, it should be kept in the child's file or central log.

Need to consider electronic medical records and protocols for record keeping based on technology.

Recordable incidents include emergency safety interventions. Is this the same as a restrictive procedure?

§23.19. Child funds.

(a) Money earned or received by a child is the child's personal property.

(b) Commingling of child and RTF funds is prohibited.

(c) AN RTF may place reasonable limits on the amount of money to which a child has access. The RTF shall develop a policy on access to a child's funds, which must be approved by the Department.

(d) AN RTF shall maintain a separate accounting system for child funds, which includes the dates and amounts of deposits and withdrawals.

(e) Except for a child expected to be in the RTF for fewer than 30 days, an RTF shall maintain an interest-bearing account for child funds, with interest earned tracked and applied for the child.

Comments:

Can a dollar amount be placed on this as was done in the interpretation of current expectations within Chapter 3800? Most banking institutions do not want to handle small amounts.

Expectations that facilities will pay interest creates yet another unfunded mandate. Is there a minimum amount that triggers the need for interest?

Legally, providers have no authority to set up an account as it must be the guardian that signs.

Bank fees will exceed any interest gained in many situations.

"The RTF shall develop a policy on access to a child's funds, which must be approved by the Department." Is this approval done as part of the review approval of the overall program description or can it be a discrete policy reviewed and approved? Does the Department have the necessary staff with relevant skills to support this process?

(f) AN RTF shall return money left in a child's account to the child upon discharge or transfer.

§23.20. Consent to treatment.

(a) AN RTF shall comply with the following statutes and regulations relating to consent to treatment, to the extent applicable:

(1) 42 PA.C.S. §§ 6301-6365 (relating to the Juvenile Act).

(2) The Mental Health Procedures Act (50 P.S. §§ 7101-7503).

(3) The act of February 13, 1970 (P.L. 19, No. 10) (35 P.S. §§ 10101-10105).

(4) 55 Pa. Code Chapter 5100 (relating to mental health procedures).

(5) The Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. §§ 1690.101-1690.115).

(6) 35 P.S. §§ 10101.0-.2 (relating to mental health treatment and release of medical records.

Comments:

Act 169 regarding substitute health care decision making should be added to this list of pertinent regulations.

Provisions of Act 147 amending the Mental Health Procedures Act should be addressed in consent requirements as well as who owns the information.

(b) The following consent requirements apply, unless in conflict with the requirements of the statutes and regulations specified in subsection (a):

(1) AN RTF shall obtain written consent upon admission, whenever possible, from a child's parent and, when applicable, a child's guardian or custodian, for the provision of routine health care such as child health examinations, dental care, vision care, hearing care and treatment for injuries and illnesses.

Comment:
How does this coordinate with later referenced expectations that the medical care providers will secure consents?

(2) AN RTF shall obtain separate written consent prior to treatment, from a child's parent and, when applicable, a child's guardian or custodian, for each incidence of non-routine treatment, such as elective surgery or experimental procedures. If the parent or, when applicable, the guardian

or custodian, cannot be located, an RTF shall obtain separate written consent prior to treatment by court order, for each incidence of non-routine treatment, such as elective surgery or experimental procedures. A CCYA that has legal custody of a child may not consent to non-routine treatment.

Comment:

Is witnessed verbal consent (by phone) unacceptable? In experience, a significant number of families fail to return consent forms, leaving a child without necessary treatment. Some provision for witnessed verbal consent should be considered to avoid the potential of provision of needed treatment being jeopardized.

Written consent is required for non-routine treatment, but non-routine treatment is not defined. Presumably, chemotherapy is a routine treatment for cancer. Would consent not be required to administer chemotherapy? Similarly, antipsychotic medication is the standard of care for treatment of schizophrenia. Is consent no longer needed because it is a form of routine treatment?

At a broader level of questioning, is the process of obtaining and collecting medical consent even the responsibility of the provider (unless of course the provider actually provides the medical treatment)? Is the collection of consent properly the responsibility of the treating physician or the hospital that provides the treatment?

(3) Consent for emergency care or treatment is not required.

§23.21. Confidentiality of records.

(a) AN RTF shall comply with the following statutes and regulations relating to confidentiality of records, to the extent applicable.

(1) 23 Pa.C.S. §§6301-6386 (relating to the Child Protective Services Law).

(2) 23 Pa.C.S. §§2101-2910 (relating to Adoption Act).

(3) The Mental Health Procedures Act (50 P.S. §§7101-7503).

(4) Section 602(d) of the Mental Health and Mental Retardation Act (50 P.S. §4602(d)).

(5) The Confidentiality of HIV-Related Information Act (35 P.S. §§7601-7612).

(6) 55 Pa. Code §§ 5100.31-5100.39 (relating to confidentiality of mental health records).

(7) 55 Pa. Code §§3490.91-3490.95 (relating to confidentiality).

(8) 35 P.S. §§ 10101.0-.2 (relating to mental health treatment and release of medical records).

(9) The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule (45 CFR Parts 160 and 164, Subparts A and E).

(10) 42 CFR Part 2 (relating to confidentiality of alcohol and drug abuse patient records).

(b) The following confidentiality requirements apply unless in conflict with the requirements of the statutes and regulations specified in subsection (a):

(1) A child's record, information concerning a child or family, and information that may identify a child or family by name or address, is confidential and may not be disclosed or used other than in the course of official RTF duties.

(2) Information specified in paragraph (1) shall be released upon request only to the following:

(i) A child's parent.

Comment:

Act 147 - can a child 14 or older restrict this?

(ii) A child's guardian or custodian.

(iii) The child's and parent's attorneys.

(iv) Court and court services, including probation staff.

(v) County government agencies.

(vi) Authorized agents of the Department.

(vii) A child, if the child is 14 years of age or older, unless the information may be harmful to the child. Documentation of the harm to be prevented by withholding information shall be kept in the child's record.

Comment:

May information be released to police in the event of a youth running away?

(3) Information specified in paragraph (1) may be released to other providers of service to the child if the information is necessary for the provider to carry out its responsibilities. Documentation of the need for release of the information shall be kept in the child's record.

Comment:

Does this indicate that providers need to wait for each instance to secure specific releases from family/guardians? Time defined releases are usually signed.

Do the sources listed in section 2 require specific signed consent by family/guardian/youth? Later in section 5, it appears as though even for the county and or Department to have access, written authorization is needed.

It appears as though there needs to be documentation of the request on the release of information form and then again separately in the record. Is there value to this redundancy?

(4) Information specified in paragraph (1) may not be used for teaching or research purposes unless the information released does not contain information which would identify the child or family.

(5) Information specified in paragraph (1) may not be released to anyone specified in paragraphs (2)—(4), without written authorization from the

court, if applicable, or the child's parent or, when applicable, the child's guardian or custodian, or the child.

Comment:

Under Act 147, the client (youth) may control the record and the parent has no standing relative to releases. Please offer clarification.

Questions asked relative to the restriction of who information can be sent to. Family can authorize these records. If it is a patient record and a valid release has been signed, why add additional parameters?

The section indicates that Information cannot be released to the Counties/Department unless approval is given by the parents or the child. This requires additional clarification.

(6) Release of information specified in paragraph (1) may not violate the confidentiality of another child.

§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.

Comment:

Clarification is required regarding the above section. What does this mean/include?

CHILD RIGHTS

§23.31. Notification of rights, grievance procedures, and consent to treatment protections.

(a) The RTF shall develop and implement written grievance procedures for a child, a child's family and staff to ensure the investigation and resolution of grievances regarding an alleged violation of a child's rights.

Comment:

The provider can make attempts but cannot ensure resolution of a grievance.

(b) A copy of a child's rights, the grievance procedures and a list of organizations that can assist in lodging grievances, and applicable consent to treatment protections shall be posted in a conspicuous and public place at the RTF.

(c) A child, a child's parents, unless court-ordered otherwise; and, when applicable, a child's guardian or custodian, shall be informed of the child rights and grievance procedures in an easily understood manner and in the primary language or mode of communication of the child and child's parent or, when applicable, guardian or custodian.

(d) A child must be informed of these rights and grievance procedures upon admission. The child's parent and, when applicable, a child's guardian or custodian, must be informed of the child rights and grievance procedures within 7 days of the child's admission, if not present when the child is admitted.

(1) A child, parent and, when applicable, the guardian or custodian, shall be given a copy of this information in writing in the primary language of the child and the child's parent or, when applicable, guardian or custodian. The RTF shall obtain a signed statement acknowledging receipt of this information to be retained in the child's file.

(2) If the RTF is unable to obtain an acknowledgement of receipt, the efforts made to obtain the signature shall be documented in the child's file.

(e) A child and the child's family have the right to lodge a grievance with the RTF for an alleged violation of the rights specified at §23.32 (relating to specific rights) without fear of retaliation.

§23.32. Specific Rights.

(a) A child may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age or sex.

(b) A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment.

(c) A child shall be treated with fairness, dignity and respect.

(d) A child shall be informed of the rules of the RTF.

(e) A child has the right to communicate with others by telephone subject to RTF policy approved by the Department, and written instructions from the CCYA, JPO or court regarding circumstances, frequency, time, payment and privacy of telephone calls.

Comments:

Need to address/include other means of communication – access to internet, text messaging and cell phones. There must be some ability to limit with these communication options.

Can the parent curtail the rights of a child? The regulation should speak to situations where communications are contraindicated – contact with a perpetrator, drug supplier, abusive family member, court ordered limitation on communication, etc.

"The RTF shall develop a policy which must be approved by the Department." Is this approval done as part of the review approval of the overall program description or must it be a discrete policy reviewed and approved?

(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.

Comments:

Will any consideration be made for distance?

Will increased funding be applicable to agencies that take children from across the state? This requirement becomes a significant unfunded mandate with fiscal implications (not allowed reimbursable costs, etc.) for transportation, staff and other accommodation costs.

How does this coordinate with clinical issues/impacts? What about psychiatrist recommended limitations/structure?

Is this construed as therapeutic leave, especially when more than 12 hours?

What about children who are not monitored by the court and there is not a court/restraining order or court relationship in place?

How are situations related to abuse allegations under investigation to be addressed? There may not yet be a court order entered as investigation/hearing is pending.

Medicaid allowable cost structure does not permit the provider costs for visiting space, meals, transportation, etc. to be included in the per diem. This section constitutes an unfunded mandate.

Are the BHMCOs prepared to address the increased costs for frequency, transportation, staffing?

Parents can become dependent on the agencies to support their relationships with the child. How can the provider move to empowering the family and supporting the transition back t their caretaker role? The clinical focus of supporting the family's ability to address their child's needs long term is negated in the presentation of the provider's role.

There is nothing in this provision for doctor orders when family contact is clinically contraindicated. Treatment facilities need to be able to prescribe what is clinically in the best interest of the resident even when that means restricting family contact until clinical work can occur.

There is nothing in this provision for children who refuse contact with their families for whatever reason, but especially for safety reasons.

Weekly family visits- would need an increase in approved/covered therapeutic leave days as it is currently only 48 which does not allow 1 time a week. But later in the regulations, it is stated that therapeutic leave is not covered.

(g) A child has the right to receive and send mail.

(1) Outgoing mail may not be opened or read by staff.

(2) Incoming mail from Federal, State or county officials, or from the child's attorney, may not be opened or read by staff.

Comment:

Consideration needs to be given for children who cannot read or who cannot even communicate the need for assistance with mail. There should be some provision for providing assistance.

May mail be opened by staff with the permission of the child?

(3) Incoming mail from persons other than those specified in paragraph (2), may not be opened or read by staff, unless the RTF has reasonable suspicion that contraband, or other information that may jeopardize the child's health, safety, or well-being, may be enclosed. If the RTF has reasonable suspicion that contraband, or other information that may jeopardize the child's health, safety, or well-being may be enclosed, mail may be opened by the child in the presence of staff.

Comments:

Does this include email? Access to cell phones, internet, etc. is prohibited by most agencies.

Who bears the cost of postage?

This does not address mail from individuals who are not permitted contact with the child. What if the parent identified limitations?

(h) A child has the right to communicate and visit privately with the child's attorney and clergy.

(i) A child has the right to be protected from unnecessary search and seizure. AN RTF must conduct search and seizure procedures, subject to RTF policy approved by the Department.

Comment:

"RTF must conduct search and seizure procedures, subject to RTF policy approved by the Department." Is this approval done as part of the review approval of the overall program description or must it be a discrete policy reviewed and approved?

Is this approval by the State or regional office? What is the process/timeline? How is this approval process initiated and documented?

(j) A child has the right to practice the religion or faith of the child's choice, or not to practice a religion or faith.

(k) A child shall have appropriate medical, behavioral health and dental treatment.

Comment:

Who pays for dental care if child is not MA eligible?

(l) A child shall have appropriate rehabilitation services.

Comment:

The proposed regulation states that a child has a right to appropriate rehabilitation services. Many providers who deal with children with autism and/or intellectual disability are not dealing with rehabilitation, but rather with habilitation. Youth have not lost skills that need to be redeveloped, but rather have never acquired the skills. Is there also a right to habilitation under these regulations?

(m) A child shall be free from excessive medication.

Comment:

Who defines excessive? The psychiatrist? The parent/guardian? The BH-MCO?

(n) A child may not be subjected to unusual or extreme methods of discipline which may cause psychological or physical harm to the child.

(o) A child shall have clean, seasonal clothing that is age and gender appropriate.

Comment:

Who is responsible for providing clothing and personal supplies? Such items are excluded from MA allowable cost calculations. Clothing is not covered by Medicaid.

(p) A child has the right to the following:

(1) To ask staff questions related to the child's treatment.

(2) To advocate for himself or herself.

(3) To disagree respectfully.

(4) To submit a formal grievance without jeopardizing the child's standing or privileges within the RTF or the right to continued services.

(q) A child shall be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Comment:

The prohibition against the use of restraint, while consistent with current philosophy regarding restraint use, does result in denying children access to an evidence based form of treatment for serious behaviors. The Association for Behavior Analysis International position statement on the use of restraint permits the use of contingent restraint as a form of treatment. Kennedy Krieger, the pre-eminent acute care behavioral treatment program in the country, employs contingent restraint on a regular basis. While recognizing that there is little choice regarding this regulation, recognition that it will deny some children treatment must be given.

(r) A child shall have a clean, healthy, and comfortable living environment.

Comment:

This is a very subjective requirement open to numerous interpretations.

§23.33. Prohibition against deprivation of rights.

(a) A child may not be deprived of the specific rights specified in §23.32 (relating to specific rights) or civil rights.

(b) A child's rights may not be used as a reward or sanction.

(c) A child's visits with family may not be used as a reward or sanction.

Comments:

Can a parent curtail their child's rights?

Family visits may not be used as reward or sanction but the family may elect to make such visits contingent upon the child's behaviors. The section should be rewritten to note that providers may not use family visits as rewards or sanctions as they have no control over the parent's approach.

Clarification of the treatment team's role in determining contact/ communication as not beneficial/appropriate/therapeutic and the actual use of the treatment plan in planning visits is requested.

Psychiatrist's liability will be enhanced as their orders can be negated; will they be willing to take on this risk? What has the AMA offered as feedback?

§23.34. Notification of RTF restraint policy.

At admission, an RTF shall:

(a) Inform both the child, the child's parent and, when applicable, the guardian or custodian, of the RTF's policy regarding the use of restraint during an emergency safety situation that may occur while the child is at the RTF.

(b) Communicate its restraint policy in a language that the child, the child's family, guardian or custodian, understands, including American Sign Language. When necessary, the RTF shall provide interpreters or translators.

(c) Obtain an acknowledgement, in writing, from the child, or in the case of a minor, from the parent or, when applicable, the guardian or custodian that he has been informed of the RTF's policy on the use of restraint during an emergency safety situation. Staff shall file this acknowledgement in the child's record.

(d) Provide a copy of the RTF restraint to the child and, in the case of a minor, to the child's parent or, when applicable, guardian or custodian in a language that the child, the child's family, guardian or custodian understands.

Comments:

It appears as though there is omission of a word in item d. "Provide a copy of the RTF Restraint..." should probably read "Provide a copy of the RFT Restraint Policy".

This section also specifies that the printed policy must be in a "language" that the child, family, guardian understand. Does this mean having this policy printed in various languages? If so, why not provide all program policies in all necessary translation? "Restraint Policy" is only one of many that parents should understand.

(e) Provide contact information, including the phone number and mailing address, for the Disabilities Rights Network.

Comments:

Please provide relevant contact information for the "Disability Rights Network".

Would this not be better placed in the section covering "Child Rights" (23.32-F) or 23.33 – "Deprivation of Rights"? Parents and guardians have a right to know they can access the network for any violation of their rights not just those related to restraint.

FAMILY PARTICPATION

§23.41. Family participation in the treatment process.

AN RTF shall ensure that a child's family is given the opportunity to participate fully in the planning for delivery of services to the child as evidenced by the following:

(1) Meetings being held at times convenient to the family with at least 2 weeks notice to maximize the possibility of family participation.

(2) ISPT meetings and other formal meetings with the family as active members of the team.

(3) Demonstrated opportunities for frequent and regular family contact including daily telephone calls and at least weekly visits at the family home or at the RTF, as well as community activities with the family within and outside the RTF to be determined as part of the treatment planning.

Daily calls and weekly visits (visits only in home or RTF - does not mention meeting point.)

Comment:

Challenges of family time running into program/therapeutic time – which takes priority?

Will costs of long distance calls be included in rates paid by Medicaid/BHMCOs?

Clarification of number of calls child can make on a daily to which/how many family members is needed. The potential for this expectation of daily contacts to interfere with the primary reason for admission to the RTF – treatment - is significant.

There are several general assumptions implied in this section that need to be considered. The first assumption is that though RTFs must give families the opportunity to fully participate in the planning for delivery of services to a child, the families may choose, at their convenience, whether or not they will participate. Families should be expected to fully participate, not only in the planning for delivery of service to their child, but also to fully participate in their own treatment as recommended. Too often families expect the RTF to 'fix' their child and send them home to an environment that has not participated in treatment and has remained the same, resulting in relapse due to unchanged family dynamics.

(4) Family therapy for the benefit of the child, as well as parent support and education groups involving parents and, when applicable, guardians or custodians, as appropriate, shall be provided to a child as part of the overall treatment offered in the RTF and documented in the child's record.

Comments:

Concerns have been identified specific to "Family therapy" being mandated for the benefit of the child. Participants in family therapy have to consent to the participation. If it is mandated, consent is meaningless.

How can one mandate a form of treatment without an appropriate diagnosis and assessment? This regulation would mandate the provision of family therapy for a child with autism who is completely unable to communicate.

The decision to provide therapy is a clinical decision, not an administrative one.

Not every child will be able to participate in family therapy, and not every child will be able to benefit from it. In some instances, the provision of family therapy might even be counter therapeutic. A better form of this regulation would be to require that each child be evaluated for possible inclusion in family therapy. Family therapy could then be mandated if there is professional judgment that the child would benefit from family therapy.

What is the intent regarding guardians and family therapy? What is extent of inclusion? How would it be beneficial for a C&Y agency with custody of the child to be connected to a support group?

Is this therapy to be offered as part of the RTF program scope or contracted through community resources? Are parent support groups to be facilitated by the RTF?

Parent education groups with the identified patient (child/youth) not participating, may not be reimbursable. Who addresses these costs? The only reference in the 'allowable cost' section indicates that the cost is allowable if the client is present.

In-home therapy is also challenge. RTF therapists may not be available/able to act in the role of a community based family therapist. Safety and time management concerns are identified. How does this expectation relate to the provision of Family Based MH Services?

How much is this taking away from treatment interventions ongoing within the RTF? How does the increased contact with families affect the child's clinical treatment if it disrupts group/social/transition times?

Infrastructure costs to the agencies will be considerable.

(5) Efforts to link the child and family with community resources, both formal human service systems and informal community supports. AN RTF shall base the choice of community linkages outside the RTF on the planned expectation that the child will be returning to the community and will need supports to assist a child in making a smooth transition.

(6) Participation of the family in making appropriate medical and medication decisions including arranging for family participation in the medical appointments when desired by the family.

Comment:

Consent for medical treatment should appear somewhere in this section, but it is notably absent. Parents should do more than merely participate in the decision making around medication and medication decisions; they have the power of consent. This should be included.

It is often a challenge to provide family advance notice regarding medical appointments if they are for an acute issue – often clinics will see the child the same day of the request.

This section does not take into account the rights of 14 year olds and older youth to make determinations about who is involved in their treatment.

(7) Participation of the family in making appropriate decisions about the child's activities and schedule.

Comment:

This expectation can become an RTF management challenge – the structure of the RTF is part of the treatment process. While the family can and should be advised as to the schedule, decision making about daily activities and schedule

are limited. This could present significant disruption in the planned structure of the RTF related to treatment of all the children in the unit.

(8) Having a formal process for families to resolve disagreements about the treatment plan or the delivery of service.

Comment:

Who is the client? The child or the family. Achieving balance between the child's treatment and family dynamics is a treatment team process/responsibility which includes family members.

This formal process would be included in the grievance procedure and/or within the treatment plan as it is developed.

(9) AN RTF shall ensure that an onsite meeting with the parents and, when applicable, the guardians or custodians, is arranged within the first 7 days of the child's admission including day of admission, unless the family is present on the day of admission. The following information shall be discussed with the family at the time of the onsite visit:

Comment:

How can the RTF ensure that an onsite meeting will take place? There needs to be a provision for what will happen if the family does not follow the family participation plan and what will the plan of correction will be.

Will the family advocate have some responsibility in monitoring the family's compliance with the participation plan as part of 'facilitating family involvement plan (23/60 (b) (7)?

Will the family advocate have a direct role with the family to ensure their compliance? Is the written family participation plan the same as the family involvement plan?

(i) Family expectations regarding the child's treatment.

(ii) The need to jointly develop a written family participation plan that identifies specific goals for family participation in the child's ongoing treatment, to be reviewed and updated at least monthly.

Comment:

Does this make child's treatment secondary? How does this mesh with court orders and BH-MCO's authorization? Or the psychiatrist's directions?

(iii) Expected length of stay and type of treatment that will be offered.

(iv) Opportunities for family-focused therapy targeted to benefit the child, using evidence-based approaches, when possible, with discussions about potential frequencies and possible locations when distance is an issue.

Comment:

The phrase "when possible" must be removed. What justification is there for using anything other than evidence based treatments? The only possible exception would be for experimental treatments, which would need to be conducted in accordance with regular scientific evaluative procedures.

(v) Information about advocacy organizations and consumer satisfaction teams that are available to assist in the lodging of grievances.

Comment:

General concerns are identified regarding the perfect world vs. the constraints of realities of treatment within an RTF setting. The RTF is not always the most appropriate option for treatment of the family. Is the Commonwealth being equally aggressive to cultivate, develop and approve and fund other options for family intervention/treatment?

§23.42. Documentation of efforts for family contacts.

AN RTF shall document in the child's record efforts to involve a child's family in service planning and delivery.

§23.43. Space onsite for family visits.

AN RTF shall have at least one designated area onsite for family visits that offers privacy for the child and family.

Comments:

With increased frequency of contacts, cost considerations and logistical challenges increase.

It may be challenging to ensure total privacy given increased number of visits to be scheduled and the physical configurations of designated space.

Such space cannot be included in facility costs.

§23.44. Assistance with coordination of transportation for family contacts.

AN RTF shall assist with the coordination of available transportation for the family's onsite participation and visits when the family needs assistance with transportation.

Comments:

What about children and youth with no families? Children and youth that have no family involvement? Are county C&Y agencies to maintain this level of involvement?

What about families that are incarcerated?

What about families restricted due to their own form of treatment?

The expected degree of family involvement in determining a treatment plan appears to conflict with federal regulations relevant to the role of the psychiatrist within the scope of the RTF.

How are situations with family member conflicts to be addressed? Custody situations? Again, what about children and youth under court supervision/in custody of the county?

It must be noted (again) that many of the resources necessary to support family participation are not allowable MA costs (food, travel, space, furnishings, etc. How will these costs be covered? What responsibilities rest with the family?

RTFs support their role to ...."assist" with the coordination of available transportation for the family's on-site participation and visits when assistance with transportation is needed. However, most RTFs are not in a position to offer actual transportation and the costs are not allowable. If this is required, how will RTFs pay for it? Staff it? What about costs associated with the on-campus family visit? Further clarification as to the level of "coordination of transportation", especially for youth that are placed outside of their home county, is needed. In researching independent transportation services many average $1.30 per child per mile.

While some RTFs are able to offer overnight lodging, most are not.

Need greater clarity as to expectations and responsibilities being imposed upon RTFs.

STAFFING

§23.51. Child abuse and criminal history checks.

Child abuse and criminal history checks must be completed for all staff in accordance with 23 Pa.C.S. §§6301-6386 (relating to the Child Protective Services Law) and 55 Pa.Code Chapter 3490 (relating to child protective services).

§23.52. Staff hiring, retention and utilization.

(a) Staff hiring, retention and utilization shall be in accordance with 23 PA.C.S. §§6301-6386 (relating to the Child Protective Services Law) and 55Pa.Code Chapter 3490 (relating to child protective services.

(b) Prospective staff responsible for providing direct care to a child shall have a pre-employment physical and drug screening.

Comments:

A traditional physical examination performed by an M.D. will not measure the capacity of a staff person to perform a physical restraint. However, it usually can serve to screen individuals who would be unable to perform.

Drug screening requirements are new. There must be recognition of costs involved. This is not required in other BH treatment settings – why in RTFs?

What is the degree of drug testing/screening is to be required? There are various levels.

There is no exemption for a pre-employment physical conducted within a certain time frame for other employment.

§23.53. RTF director.

(a) There shall be one director responsible for the RTF

(b) The director shall be responsible for the administration and management of the RTF, including the safety and protection of the children, implementation of policies and procedures and compliance with this chapter.

(c) The director shall have one of the following:

(1) A master's degree from an accredited college or university and 2 years work experience in administration or human services.

(2) A bachelor's degree from an accredited college or university and 4 years work experience in administration or human services.

§23.54. Medical director.

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

Comments:

It must be recognized that psychiatry has become a largely biological profession, with many exceptionally competent psychiatrists having little to no experience in the provision of therapy or the overall operation of programs.

The clinical director should be the one in charge of overseeing the delivery of services and programs to children. Nothing would prevent the psychiatry (or medical) director from serving as clinical director, but this position should be open to other professionals of equal qualifications and license.

This position should be viewed as totally clinical in scope and should not be included as part of the administrative cost structure or included in the proposed 13% admin cap.

This position might be better titled "Psychiatry Director?" It would seem that medical director is a title that should be reserved for someone with training in pediatrics or internal medicine. While psychiatrists are physicians, they are

specialists. Many lack the professional competence to function as a medical director. Many psychiatrists decline providing general physical health care due to liability concerns.

(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.

Comments:

Accreditation does not require this.

This amount of time required is unrealistic.

How stringent are these requirements – is it an average? Are there exemptions? Usually on-call coverage when on psychiatrist is on vacation does not cover normal session times.

Many providers will not be able to meet this requirement within the program's structure and availability of qualified candidates.

Need additional clarification of medical director's responsibilities vs. attending psychiatrist, especially with monitoring all children.

This is a proposed model of a physician making regular rounds as within a hospital setting. This is not reflective of current practice.

What is the research or evidence for this practice recommendation? The Commonwealth should not be dictating the work at this level.

Time frames should not be regulated but rather driven by case-by-case treatment needs.

It is difficult to get psychiatric time to fulfill current 1 hr per month per child. While the concept is a good one, implementation is not feasible – are there that many psychiatrists in PA?

Many of the duties listed here are descriptive of a staff psychiatrist, not necessarily a medical director. The creation of a section for staff psychiatrists duties, prerequisites, payment etc is suggested.

Re: Medical Director requirement. Where/how do the part-time arrangements fit into this staffing role? Some RTFs contract for this psych support through several PT practitioners?

What is the requirement for documentation of tracking time - at least 2 hours per week of psychiatric time for every 5 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.

(3) Regular and ongoing contact with treatment staff to formulate and monitor the implementation of the child's treatment plans.

(4) Regular and ongoing face-to-face or phone contact with a child's family.

Comments:

How will unavailability of family be addressed – psychiatrists often try to call the family but they are not available; DPW licensing reps have stated that attempts do not count.

Define expectations of 'regular' contact with child's family.

What about conflicts within the family? Children and youth that have no family involvement? Families that are in their own treatment or incarcerated?

Documentation? Demands on time could be considerable cost factors.

(5) Regular and ongoing contact, as appropriate, with external, community agencies and natural supports important to a child's live, including informal

networking and face-to-face participation in ISPT and treatment team meetings.

Comments:

This is normally a process that is delegated by the psychiatrist to other staff. Is this really a justifiable use of the psychiatrist's time?

Concerns are noted with references and costs associated with "informal networking" expectations.

Costs for psychiatric time and the relationship to Governor Rendell's Prescription for PA and allowing practice within scope of license (i.e. nurse practitioner), supervision, etc, must be addressed and coordinated. How will this be carried over into a new administration? What is the reaction of the AMA to this requirement?

These additional responsibilities are financially unrealistic. This would be above and beyond the direct contact with children mentioned above. That means much more time than outlined in (1) and is that much more unrealistic.

Cost issues and availability of hours are a concern throughout this section.

Bureau of Program Integrity compliance – how does this connect with these responsibilities and duties of a Medical Director?

(6) Preparation of formal, written psychiatric evaluations as required.

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

Comments:

Why the Commonwealth is attempting to structure the internal program operations of an RTF?

The Clinical Director should be responsible for the coordination and supervision of RTF staff, including the psychiatry director. The medical/psychiatry director should be reporting to the clinical director who actually runs the program.

There must be room to allow for the RTF program to decide how to best establish an organizational structure that will maximize service/achieve outcomes for children.

Coordination of staffing is the director's job as an administrative function and not one that should be under the purview of the Medical Director.

Differentiation between clinical plans (psychiatrically supervised system of care) vs. community based system of interventions must be addressed.

Clearer/cleaner differentiation between roles/responsibilities of medical director vs. supervising psychiatrists is needed if the Commonwealth is intent on micromanaging through regulation.

What are the connections between this section and federal CMS requirements?

Best practice – is the medical model considered the best practice? If not, what other best practices contradict this model and, in turn, philosophical constructs of these regulations? What are the evidence base/research citations for these requirements as best practice?

Is there research to support that more psychiatric contact means better outcomes?

Does the psychiatrist have to be involved in the medication review for physical health care issues? Do they need additional insurance to do medication review if meds are for general health care reasons? Many psychiatrists decline providing general physical health care due to liability concerns.

§23.55. Clinical director.

(a) There shall be one clinical director who ensures that staff receives training and clinical supervision.

(b) The clinical director shall be a licensed psychologist, a licensed clinical social worker, or a licensed marriage and family therapist, with at least 2 years of experience providing therapeutic interventions to children with serious emotional or behavioral disorders.

Comments:

Should include Licensed Professional Counselor (LPC) with LCSW and LMFT.

Can other degrees be grandfathered in/waivered? LCSW +2 years/and LSW +4?

Can the clinical director also be RTF director as long as duties are covered?

The clinical director should be excluded from the administrative percentage calculations

(c) The medical director may serve as the clinical director provided that the medical director has at least 2 years of experience providing therapeutic interventions to children with serious emotional or behavioral disorders.

Comment:

The 2 years of experience referenced above is already part of the requirements for qualifications for Medical Director.

§23.56 Mental health professional.

(a) The mental health professional shall have the following duties:

(1) Participating on the treatment team.

(2) Ensuring the implementation of the treatment interventions, therapeutic activities, and schedule for the children.

(3) Supervision of mental health workers.

Comments:

What the inclusion of direct supervision of MH workers? Most RTFs delegate supervision to the clinical director. Why the need for such prescriptive responsibilities?

Clarification is needed - Can the clinical director also work as a mental health professional?

(b) The mental health professional shall have the following:

(1) A graduate degree in a generally recognized clinical, mental health discipline such as psychiatry, social work, psychology, counseling, nursing, rehabilitation or activities therapies.

(2) At least 1 year of clinical experience working with children in a behavioral health program whose operating principles were in accordance with CASSP principles.

Comments:

Is this a 1 and 2 requirement or a 1 or 2 requirement?

This devalues child care professionals who may not have the degree but know how to effectively interact with youth in RTF programs.

There is no recognition of trainings and/or experience as part of the qualifications. Please reconsider. The risk of losing long term, credible staff is significant.

This requirement micromanages programs.

In more rural areas, and with competition within urban areas, these requirements will limit availability of workforce to fill them, especially for weekends and holidays.

Salary scales and competition with medical and nursing care facilities will present significant challenges. This requirement has significant cost implications. Are the BH-MCOs prepared to address these increased costs?

Please consider inclusion of licensing or licensing requirements as an option for qualifications of those without graduate degrees. Suggest revision to graduate degree or state license. Add graduate degree or "or hold a current professional license" in a generally recognized clinical, mental health discipline including, but not limited to, psychiatry, social work, psychology, counseling, "marriage and family therapy", nursing, rehabilitation or activities therapies.

The Mental Health Professional clinical experience should include "or practicum/internship experience"

§23.57 Mental health worker and mental health aide.

(a) The mental health worker shall be responsible for implementing therapeutic interventions.

(b) The mental health worker shall meet one of the following requirements:

(1) Have at least 1 year of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles and a bachelor's degree, with at least 12 credit hours of education in psychology, sociology, social work, counseling, nursing, education or theology.

(2) Be a licensed registered nurse and have at least 1 year of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles.

(3) Have a high school diploma or equivalent and at least 4 years of experience in a children's behavioral health program whose operating principles were in accordance with CASSP principles.

(c) A mental health aid shall have a high school diploma or general education development certificate.

Comments:

What is a mental health aide able to do within the RTF setting? Can they only work overnight? BHMCOs do not accept this staffing level in practice?

Need to move RN out of this category - they have a totally different role and different requirements, cost factors and utilization, entry salary of an RN vs. entry pay level for other workers is significant; RNs need to be in a separate category.

No Associates Degree mentioned

New requirements eliminate value of previous experience.

How do staff get the 1 year of experience if you can not be hired without it? You would have to be hired as a mental health aid first which does not require a degree. It will be difficult to recruit degreed individuals at this level.

§ 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.

Comments:

Who are these clinical consultants within the Department?

On what criteria are the consultants basing their decision?

Why does the Department believe they need to resort to this level of micromanagement?

Awake Hours - School hours - are requirements still the same? Need clarity as school hours are not reimbursable.

Are ratios to be based on the on-ground census?

(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.

Comment:

Is the MH worker different from MH professional?

Does this require a MH professional on call and a MH worker present with the child even if there is only one child in the RTF?

In a facility with 12 clients that would be 3 direct care and 2 MH professionals on every waking hour shift. This would be a significant increase in costs to have 5 staff for 12 clients working each of the 2 shifts between 7 am to 10 pm.

(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.

Comment:

Move this (3) under (5) – appears to be misplaced

(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.

Comment:

Who is present — 6 children present or 1 MH professional present? Or both. This is confusing language. Needs clarification.

What is the ratio during day vs. night, and do they need to be onsite or on call? Need examples.

This would require 6 FTE of Masters level MH professionals for every 12 children? 3 MH workers, 2 MH professionals during waking hours for 12 children. Refutes idea of cost neutrality.

Is the intent to say "need the MH professional to be available nights/weekends?"

Clarify #4 (what does this mean; provide samples)

Clinicians are not being trained to be in supervisory roles

Units are staffed differently, based on the ages, client's diagnosis, etc. this is too prescriptive

(5) During sleep hours, 1 mental health worker or mental health aide shall be present with every 6 children.

Comment:

Most RTF are currently at 8:1 so this makes for doubling of staff.

Need examples.

Cost and hiring considerations are significant. Are these workers even available?

This proposal will result in two staff per unit overnight once the unit census reaches 7 children. Again, this level of staffing seems excessive. It is more imperative that the staffing ratios be adjusted as indicated by the population served and the severity and complexity of the presenting behavior. Providers must continually evaluate the staffing needs and adjust accordingly so that the safest environment possible is provided.

(6) Staff may not sleep while being counted in the staff to child ratios.

Comments:

No inclusion of associate's degree level of education. Please reconsider.

What are plans for supporting increased rates to adjust wage scales and be able to pay/retain a worker with this level of experience?

No grandfathering inclusion for current employees. This is a significant concern.

Eliminates ability to hire college juniors and seniors and interns if they are not 21.

Micro-prescriptive and a significant cost factor. Current buildings and facilities were designed with a staffing structure in mind that is different from this. Some physical structures cannot be reconfigured without significant expense.

There are significant implications for on-site schools and staffing expectations during awake hours.

Reality is that RTFs have excellent staff with lower education and less effective staff with higher educational background. More education does not automatically equate with skill/effectiveness.

(g) The mental health aide shall have a high school diploma or general education development certificate.

(h) A mental health worker or mental health aide who is counted in the worker to child ratio shall be 21 years of age or older.

Comments:

This eliminates summer employment opportunities (and thereby a recruitment option) for many college students.

Does not recognize costs and realities of coverage for weekends and holidays.

Appropriate staffing patterns need to be addressed in program descriptions, not prescribed in regulations.

Providers identify concern in using aides for overnight coverage as immediate interventions are often needed.

Flexibility is needed.

Staffing patterns are most appropriately reflected in program descriptions. Variations in program staffing need to be emphasized in program descriptions and support variations in rates.

Cost implications and annual re-assessment of rates is critical if these standards are adopted. This requirement mandates more staff without assurances that the fiscal implications will be addressed in an equally direct manner.

Realities and costs of salaries and staffing must be interjected into this section.

Differentiation between smaller community-based programs and larger cottage-based programs where professional staff may just be in the next building must be considered in this requirement.

Recent wage and hour interpretations as to exempt/non-exempt status may have huge cost implications including overtime costs.

Long term lack of ability to adjust wage standards to be competitive from the onset of implementation of this Chapter will present significant challenges in recruiting and retaining staff.

It must be emphasized that the Mental Health Worker position is an entry level position into the entire social service profession. The Mental Health Worker position is the position through which people get experience and typically move on from after a few years of experience. They do not move into this role with this experience. The position has a high level of burn out due to the severity (which is increasing) of the population as well as the non-family friendly shifts (3-11 and weekends) that are due to the 24-hour nature of RTF.

It is not best practice to require credentialing that virtually guarantees that positions will be impossible to fill and therefore there will not be enough staff to adequately address the needs of the children in a facility.

Evidence base supporting this staffing configuration as being most appropriate options?

BH-MCOs should be required to provide recidivism rates to create a baseline in view of priority of shorter lengths of stay and increased staffing qualifications

§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.

Comments:

This again presents an attempt on the part of the Department to micromanage RTF operations and staffing roles.

This is overly prescriptive.

Can several people fill this role? Can one person do all of this? Again, this determination should be one made by the RTF and not prescribed in regulations.

Why does one specific person have to take on all these roles?

(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.

(2) Participation in the high-fidelity wraparound, if the child and family have a high-fidelity wraparound team.

Comments:
The proposed regulations refer heavily to participation in the high-fidelity wrap around process, however, these process is currently only available in 6 counties

in the Commonwealth with limited expansion planned, and then only to narrowly defined population sub-groups.

Community-based services as aftercare providers are already at capacity and will be impacted by these proposed regulations, as they may not be able to provide the level of care required.

(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.

Comments:

It should be noted that not every child in an RTF will be eligible for MA.

Some children are referred by their school districts, and as such, they may be on their parents' regular insurance policies, or they may have no insurance at all.

If the intent of the Department is to be prescriptive of responsibilities, should responsibility to "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." be delegated to the medical or clinical director?

(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).

Comments:

What if this cannot take place by family decision/choice? Can attempts be documented?

This directive should state, "The RTF shall make reasonable efforts to hold a meeting (face to face, by telephone or by other means) with a resident's parents or legal guardians within 7 days of the resident's admission." Options for this to be addressed through community visit, on-site, electronically, phone- due to distant and possibility of parents' situation. Parents may be incarcerated or in treatment themselves, limiting access. How will C&Y situations with no family involvement be addressed?

§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.

Comments:

One family advocate per agency? Facility? Per specific number of children?

Prorated hours for smaller facilities?

What is the Department's expectation for who does the family advocate reports to?

Given the scope of (b) in this section, does it create a potential conflict for an advocate to be employed by the RTF? Should this not be an independent person that would perform the scope of (b)?

(b) The responsibilities of the family advocate include the following:

(1) Participating in quality improvement activities.

(2) Ensuring restraint reduction activities.

Comment:

The focus on restraint reduction makes the faulty assumption that all restraint use is inappropriate. Clearly, there are situations in which restraint is the appropriate response. The focus should be on reducing the frequency of behaviors that would legitimately warrant the use of restraints. In doing so, restraint use should decline. Increased attention and support for the use of evidence based behavior modification programs would better serve to reduce the frequency of restraint use.

(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.

§23.61. Supervision.

(a) AN RTF shall ensure that a child is supervised during awake and sleeping hours by conducting observational checks of each child at least every 15 minutes.

Comment:

The proposed regulation requires 15 minutes observation checks of the child. What consideration is given to the child whose team has concluded his behavior is such that greater levels of independence are essential to his continuing development? An example might be the child who secures a job at the local McDonalds. Should staff stop by the McDonalds every 15 minutes to check on the child? There needs to be team-based, plan specific latitude in this area.

(b) Observational checks of a child specified in subsection (a) shall include actual viewing of each child.

Comment:

What if otherwise stated in treatment plan or by doctor? Flexibility/waiver options needed.

How does this apply to older youth connected to an IL program? Public schools? Passes going home for visits? Inflexible.

Does not fit with least restrictive educational environment/setting.

(c) Observational checks must be documented.

Comment:

This constitutes considerable documentation – is this the best use of staff time?

Need clarification of purpose as it appears to be at cross-purposes for discharge planning/developing life skills and surviving in their home community.

Developmental needs and supporting independence are not addressed or supported with this structure.

Potential conflicts with patient right to privacy are a concern.

What is envisioned as documentation requirements?

Will electronic monitoring be accepted as "observational checks?"

§23.62. Staff training.

(a) Prior to working with a child, staff, including temporary staff and volunteers, shall have an orientation to their specific duties and responsibilities; policies and procedures of the RTF, including reportable incident reporting; discipline, care and management of children; and use of restrictive procedures.

Comments:

Definition of volunteers must be revisited.

How will outside groups coming into RTF to volunteer be addressed?

If there are extensive training requirements for volunteers it will result in reduced/no volunteers. Unclear as to how much training is needed by volunteers.

This will impact interns as unpaid positions/volunteers.

(b) Prior to working alone with a child and within 120 calendar days after the date of hire, staff, including temporary staff, shall have at least 30 hours of training in the areas specified in this paragraph.

Comment:

Implications of definitions of "staff" needing 30 hours of training, as roles differ greatly within RTF staffing arrangements from support and non-direct service staff (horticulturalist, kitchen staff, etc.) to direct therapists are considerable. How does this connect with the definition of "staff" as referenced above?

If staff has completed comparable training within 12 months prior to the date of hire, the requirement for training in this paragraph does not apply. Training shall include at least the following areas:

(1) The requirements of this chapter.

(2) 23.Pa.C.S. §§6301-6386 (relating to Child Protective Services Law) and 55 Pa.Code Chapter 3490 (relating to child protective services).

(3) Fire safety.

(4) First aid, Heimlich techniques, cardiopulmonary resuscitation and blood-borne pathogen training taught by an individual certified as a trainer by a hospital or other recognized health care organization.

Comments:

The Heimlich technique is no longer included in trainings of First Aid and CPR.

(5) Crisis intervention, including use of relationships and de-escalation approaches, positive behavior support, suicide prevention, and proper, safe use of restraint when it is necessary as an emergency measure to maintain the safety of the child and others, using the least restrictive restraint intervention needed to address the crisis.

(6) Health and other special issues affecting the population.

(7) Use of assessment, evaluation and treatment plans as guides to understanding a child's strengths and needed supports in the milieu.

(8) Principles of milieu treatment and the specific roles of staff in maintaining the therapeutic milieu.

(c) Ongoing annual training.

Comments:

COST!

Clarification of how this section is written – requirements for training beyond the first 120 days?

Redundancy of having these all be annual trainings – takes up all the time, not allowing for additional skill development.

This prescriptive list takes away from being able to address specific of populations served within an individual RTF. Trauma care?

Expectations as presented are confusing. Are 40 hours plus 20 hours plus restraint training required?

(1) After initial training, staff, including temporary staff, shall have at least 40 hours per year of training relating to the care and management of children. This requirement does not apply to the initial year of employment unless the person to be trained was exempt from subsection (b) above.

(2) Staff shall complete training in first aid, Heimlich techniques and cardiopulmonary resuscitation taught by an individual certified as a trainer by a hospital or other recognized health care organization. Staff shall demonstrate their competency on an annual basis even if the certification is for longer then 1 year.

Comments:

This clearly exceeds recommended frequency for recertification as prescribed by certification entities. To what benefit/gain? And how can the cost be justified?

Design shows that 69 hours of training are needed

Fire & Safety expert to teach? Fire safety can now only be taught by a fire safety expert?

It is assumed that competency must be demonstrated to a certified trainer on an annual basis. If an agency does not have a certified trainer and annual training is required for all staff, an additional financial burden will be incurred (i.e. 20 staff x $35 / yr = $700).

(3) In an RTF serving more than 20 children, staff shall complete training in fire safety taught by a fire safety expert.

(4) In an RTF serving 20 or fewer children, staff shall complete training in fire safety taught by a staff trained by a fire safety expert. Video tapes prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff trained by a fire safety expert.

(5) A total of 20 hours of training in the following:

Comments:

Is the 20 hours referenced in this proposed regulation included in the annually required 40 hours of training, or is it in addition to the mandated 40 hours? This needs to be clarified.

This subsection requires 40 hours of annual training for staff – 20 of those 40 hours are to be focused on 18 different topical areas. In addition, staff must (d.) have emergency intervention training with highly specified requirements (13). This (d) must be accomplished twice each year. It should be noted that there are no hour requirements for this semi-annual mandate suggested in the proposed regulations. Assumptions regarding fiscal impact of the requirements as being neutral are inaccurate.

This training will require more time than the regulations suggest making the fiscal implications substantial.

The scope of required training will restrict in-depth training in areas identified as priorities within the RTF.

(i) Professional ethics and conduct and legal issues including professional boundaries with children and their families; child and general protective services; mandated child abuse reporting; and confidentiality.

(ii) CASSP principles and implementing and supporting those principles in clinical practice.

(iii) Cultural competency as described in the Cultural Competence Clinical/Rehabilitation Standards of Practice published by the Department and available at www.parecovery.org .

(iv) The Department's Special Transmittal on Strategies and Practices to Eliminate the Unnecessary Use of Restraint issued on January 30, 2006 or subsequent updates.

(v) RTF policy, including the ability to effectively transfer the application of policy and procedure to the direct care work with a child and a child's family.

(vi) Trauma-informed care, including its provision as part of ongoing care, and attachment issues.

Comment:

Does trauma informed care have the substantial empirical support needed to warrant inclusion as a regulation?

Why is training in trauma informed care to be mandated by regulation, while therapeutic strategies with significantly greater degrees of empirical evidence, such as applied behavior analysis, are not included?

(vii) Signs and symptoms of abuse and neglect.

(viii) Serious emotional or behavioral disorders and other behavioral health needs in children as they relate to the biopsychosocial needs of the children being served.

(ix) Applicable state laws related to the scope of practice for medication administration.

(x) Psychotropic medications, including types, appropriate uses and possible side effects.

(xi) The discharge process.

(xii) Cross-system training appropriate to the population the RTF serves.

(xiii) Current clinical practice and methodologies, including evidence-based practices to address the unique characteristics of the children served and the role of staff in maintaining a therapeutic milieu.

(xiv) Documentation skills and requirements.

(xvi) Recovery and resiliency in children and their families, including how to integrate these philosophies and concepts into treatment approaches for a child and the child's family during the child's RTF stay.

(xvii) Principles of participation on a high fidelity wraparound team.

(xviii) Principles of child development appropriate for the age of the children served.

(xv) Other topics appropriate to the age, characteristics, diagnosis, and developmental needs of the children served.

Comments:

There are huge cost and time implications for providing/completing the mandatory training as listed. The focus on mandated training will deplete efforts to provide program-specific/clinical training.

Suggestion to consider including broader time frames (i.e. 2 years) offered.

Does this exempt psychiatrists? The value of them attending fire safety training and the cost for them attending other requisites is cost prohibitive.

Latitude within program descriptions is requested – RTFs are already required to develop training plans for staff/agency.

Too many 'have-to's without accommodation of need for other 'want-to' training;

Inconsistency with what is covered in other sections (i.e. CPSL, CASSP principles, etc.); should be a minimal list of 'have-to's, which eliminates the ability to do program-specific trainings.

The proposed regulations refer to participation in high-fidelity wrap around, however, this process is currently only available in 6 counties in the Commonwealth with limited expansion planned, and then only to narrowly defined population sub-groups.

(d) Restrictive procedure training.

(1) In addition to the ongoing annual training listed in subsection (c), staff who are responsible for administering restrictive procedures shall demonstrate competency on a semi-annual basis in the use of interventions they are permitted to use, and knowledge of the specific circumstances and limited indications for their use.

(2) Only staff trained in the application of the type of restraint to be used may restrain a child during an emergency safety situation.

(3) Training in restraint techniques must include the following:

(i) Techniques to identify staff and child behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint.

(ii) De-escalation techniques and alternative nonrestrictive strategies.

(iii) Knowledge of normal behavior reactions to stress at various ages.

(iv) Nonphysical intervention skills.

(v) The least restrictive intervention based on an individualized assessment of a child's medical or behavioral status or condition.

Comments:

Least restrictive is a term that professionals have failed to define in any meaningful way, and its inclusion in the proposed regulations will only continue the confusion that the terms create.

Most academic considerations of the topic recognize that least restrictive is a mathematical summary of treatment efficacy, treatment duration, distress caused by the treatment, and distressed caused by the continuing emission of the behavior (cf. Axelrod, Spreat, Moyer, & Berry, 1993).

Few people providing the training and even fewer receiving the training are prepared for an adequate review of the exceptionally complex topic. Oversimplification of the topic results in a gross misunderstanding of the issue.

(vi) Techniques and procedures appropriate for the age and weight of the children served.

(vii) The safe application and use of restraints used, including how to recognize and respond to signs of physical and psychological distress, for example, positional asphyxia.

(vii) Health risks for a child associated with use of specific procedures.

(ix) Monitoring of the physical and psychological well-being of a child who is restrained, including respiratory and circulatory status, skin integrity, vital signs and any special requirements specified by policy associated with the 1-hour face-to-face evaluation.

(x) First-aid techniques and certification in the use of cardiopulmonary resuscitation, including required annual recertification.

(xi) Response to the child's emotional and mental state after use of a restrictive procedure.

(xii) First-hand experience of the specific techniques taught after demonstration by a qualified trainer.

(xiii) A testing process to demonstrate understanding of and ability to apply specific procedures. Staff may only apply procedures in which they have been trained and shown mastery.

Comments:

Cost implications must be addressed, even if best practice; otherwise this is an unfunded mandate which cannot be supported. These requirements cannot be portrayed as cost-neutral in the fiscal impact analysis.

There is a general sense that although the Department is proposing training opportunities for staff to work toward the stated goal of restraint elimination, there has been no coordinated plan or commitment of funding to support this.

What curricula are currently approved as training options? Which will be approved?

For Sanctuary certified sites, trauma informed care training may look very different from those cites excluded from state supported process. Does this add to inequity in service delivery?

Nothing is identified regarding other supported interventions including access to training on High Fidelity Wraparound.

Web based or virtual training allowed?

(e) Serving children with ASD.

(1) Staff of an RTF that proposes to treat children with ASD shall have training specific to the needs of children with ASD.

(2) The trainings under paragraph (1) must be in protocols that yield success with children diagnosed with ASD, such as applied behavior analysis, relationship-based interventions, targeted social skills instruction, strategies to support sensory needs, and functional behavioral assessment.

(f) A record of training including the name of the trained individual, along with the date, source, content, length of each course and copies of any certificates and documentation of competencies received, shall be kept in each staff training file.

General comments related to staffing and training requirements:

The proposed changes will have a detrimental effect on work force development as there is limited opportunity for upward mobility.

Staffing qualifications and ratio proposals will be extremely difficult to comply with, especially in more rural areas. This is particularly true for professional medical, nursing and mental health staff.

There are significant cost implications as this will also require substantial increases in compensation in order to compete in the local and regional labor markets.

There are significant cost implications specific to the training requirements as proposed. Such an exhaustive listing of required areas of training dilutes the content and offers only superficial review or will require extremely high numbers of training hours. This adds additional costs not only for staffing but also connected with accessing experienced, quality individuals to conduct the training.

The proposed listing of training requirements also limits individual program management decisions as to topics needed by RTFs to most appropriately respond to the populations served.

PHYSICAL SITE

§23.81. Physical accommodations and equipment.

AN RTF shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a child with a disability.

Comment:

What kind of accommodations/equipment? For any disability? What are expectations of accommodation? Compliance with ADA? Funding for modifications?

Has consideration been given to how this will affect admissions to some RTFs?

§23.82. Poisons.

(a) Poisonous materials shall be kept locked and inaccessible to a child.

(b) Poisonous materials shall be stored in their original, labeled containers.

(c) Poisonous materials shall be kept separate from food, food preparation surfaces and dining surfaces.

§23.83. Heat sources.

Heat sources, such as hot water pipes, fixed space heaters, hot water heaters and radiators, exceeding 120°F that are accessible to a child, shall be equipped with protective guards or insulation to prevent a child from coming in contact with the heat source.

§23.84. Sanitation.

(a) Sanitary conditions shall be maintained.

(b) There may be no evidence of infestation of insects or rodents in an RTF.

Comment:

What if work to resolve the problem is in process?

(c) Trash shall be removed from the premises at least once a week.

(d) Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

(e) Trash outside the RTF shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

§23.85. Ventilation.

Living areas, recreation areas, dining areas, bathrooms, bedrooms and kitchens shall be ventilated by at least one operable window or mechanical ventilation.

§23.86. Lighting.

Rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps and fire escapes shall be lighted to avoid accidents.

§23.87. Surfaces.

(a) Floors, walls, ceilings, windows, doors and other surfaces shall be free of hazards.

(b) AN RTF may not use asbestos products for renovations or new construction.

§23.88. Water.

(a) AN RTF shall have hot and cold water under pressure.

(b) Hot water temperature in areas accessible to a child may not exceed 120°F.

(c) AN RTF that is not connected to a public water system shall have a cloiform water test at least every 3 months, by a Department of Environmental Protection-certified laboratory, stating that the water is safe for drinking. Documentation of the certification shall be kept.

§23.89. Air temperature.

(a) Indoor temperature shall be at least 65°F during awake hours when a child is present in the RTF.

(b) Indoor temperature may not be less than 62°F during sleeping hours.

(c) When indoor temperature exceeds 90°F, mechanical ventilation such as fans or air conditioning shall be used.

§23.90. Communication system.

(a) AN RTF shall have a working, noncoin-operated, telephone with an outside line that is accessible to staff in emergencies.

(b) AN RTF shall have a communication system to allow staff to contact other staff in the RTF for assistance in an emergency.

§23.91. Emergency telephone numbers.

Telephone numbers for the nearest hospital, police department, fire department, ambulance and poison control center shall be posted on or by a telephone with an outside line.

§23.92. Screens.

Windows, including windows in doors, shall be securely screened when doors or windows are open.

Comment:

Can an exception be made to this requirement if a facility has a working AC system/climate control system? Screens are easily broken often and difficult to maintain.

§23.93. Handrails and railings.

(a) A ramp, interior stairway and outside steps exceeding two steps shall have a well-secured handrail.

(b) A porch that has over an 18-inch drop shall have a well-secured railing.

§23.94. Landings and stairs.

(a) There shall be a landing which is at least as wide as the doorway, beyond each interior and exterior door which opens directly into a stairway.

(b) Interior stairs shall have nonskid surfaces.

§23.95. Furniture and equipment.

(a) Furniture and equipment shall be free of hazards.

(b) There shall be enough seating furniture to accommodate the largest group of children that may routinely congregate in a room so that no child is required to sit on the floor.

(c) Power equipment shall be kept in safe condition.

(d) Power equipment, excluding normal household appliances, shall be stored in a place that is inaccessible to children.

(e) Power equipment, excluding normal household applications, may not be used by children except under supervision of staff.

§23.96. First aid supplies.

AN RTF shall have a first aid manual, nonporous disposable gloves, antiseptic, assorted band-aids, adhesive bandages, gauze pads, thermometer, tape, tweezers and scissors that are stored together.

§23.97. Elevators.

An elevator shall have a valid certificate of operation from the Department of Labor and Industry in accordance with 34 Pa.Code §7.15 (relating to inspection).

§23.98. Indoor activity space.

AN RTF shall have separate indoor activity space for activities such as studying, recreation and group activities.

§23.99. Recreation space.

AN RTF shall have regular access to outdoor, or large indoor, recreation space and equipment.

§23.100. Exterior conditions.

(a) The exterior of the building and the building grounds or yard shall be free of hazards.

(b) Outside walkways shall be free of ice, snow and obstruction.

§23.101. Firearms and weapons.

Firearms, weapons and ammunition are not permitted in an RTF or on the RTF grounds, except for those carried by law enforcement personnel.

§23.102. Child bedrooms.

(a) A single bedroom shall have at least 70 square feet of floor space per child measured wall to wall, including space occupied by furniture.

(b) A shared bedroom shall have at least 60 square feet of floor space per child measured wall to wall, including space occupied by furniture.

(c) No more than two children may share a bedroom.

Comment:

Is this limitation based on research? If so please share the citation.

(d) Children of the opposite sex may not share a bedroom.

(e) Ceiling height in each bedroom shall be at least an average of 7 ½ feet.

(f) A bedroom shall have a window with a source of natural light.

(g) A child shall have the following in the bedroom:

(1) A bed with solid foundation and fire-retardant mattress in good repair.

(2) A pillow and bedding appropriate for the temperature in the RTF.

(3) A storage area for clothing.

(h) Cots or portable beds are not permitted.

(i) Bunk beds must allow enough space between each bed and the ceiling to allow a child to sit up in bed.

(j) Bunk beds shall be equipped with securely attached ladders capable of supporting at least 250 pounds.

(k) The top bunk of bunk beds shall be equipped with a secure safety rail on each open side and open end of the bunk.

(l) A bedroom may not be used as a means of egress from or access to another part of the RTF.

§23.103. Bathrooms.

(a) There shall be at least one flush toilet for every six children.

(b) There shall be at least one sink for every six children.

(c) There shall be at least one bathtub or shower for every six children.

(d) There shall be slip-resistant surfaces in bathtubs and showers.

(e) Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

(f) There shall be at least one wall mirror for every six children.

(g) An individual towel, washcloth, comb, hairbrush and toothbrush shall be provided for a child.

(h) Toiletry items including toothpaste, shampoo, deodorant and soap shall be provided.

(i) Bar soap is not permitted unless there is a separate bar clearly labeled for each child.

§23.104. Kitchen areas.

(a) AN RTF shall have a kitchen area with a refrigerator, sink, cooking equipment and cabinets for storage.

(b) Utensils for eating, drinking and food serving and preparation shall be washed and rinsed after each use.

(c) Food shall be protected from contamination while being stored, prepared, transported and served.

(d) Uneaten food from a person's dish may not be served again or used in the preparation of other dishes.

(e) Cold food shall be kept at or below 40°F. Hot food shall be kept at or above 140°F. Frozen food shall be kept at or below 0°F.

§23.105. Laundry.

Bed linens, towels, washcloths and clothing shall be laundered at least weekly.

§23.106. Swimming.

(a) Above-ground and in-ground outdoor pools shall be fenced with a gate that is locked when the pool is not in use.

(b) Indoor pools shall be made inaccessible to children when not in use.

(c) A certified lifeguard shall be present with the children at all times while children are swimming.

(d) The certified lifeguard specified in subsection (c) may not be counted in the staff to child ratios specified in §§23.56 and 23.58 (relating to mental health professional; and staff ratios).

FIRE SAFETY

§23.121. Unobstructed egress.

(a) Stairways, hallways, doorways, passageways and egress routes from rooms and from buildings shall be unlocked and unobstructed, unless the fire safety approval specified in §23.15 (relating to fire safety approval) permits locking of certain means of egress under the following circumstances:

(1) A locked facility is medically necessary for the safety of a child through:

(i) Internal locks within the building or external locks.

(ii) Secure fencing around the premises of the building.

(2) A child needs immediate admission to locked facility for treatment of behavioral health needs and has associated child-safety or protection needs as determined by CCYA or the juvenile court.

(3) AN RTF service description has been approved by the Department and contains information regarding the security of the RTF in addition to information that demonstrates a level of clinical treatment that is beyond the standard level of service expected within a non-treatment focused locked residential facility.

(b) Doors used for egress routes from rooms and from buildings may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of a child from the building.

Comment:
This standard appears in the Chapter 3800 and the 6400 regulations. A number of providers have received waivers to install delayed door openers to reduce runaway risk. This proposed regulation should indicate that the Department is receptive to requests based on clinical need/populations served and or physical location of the RTF.

Are time delayed locks now to be totally prohibited? They are allowed now with certain approvals and the ability to be deactivated immediately in the event of emergency.

§23.122. Exits.

If more than four children sleep above the ground floor, there shall be a minimum of two interior or exterior exits from each floor. If a fire escape is used as a means of egress, it shall be permanently installed.

§23.123. Evacuation procedures.

There shall be written emergency evacuation procedures that include staff responsibilities, means of transportation and emergency location.

§23.124. Notification of local fire officials.

AN RTF shall notify local fire officials in writing of the address of the RTF, location of bedrooms and assistance needed to evacuate in an emergency. The notification shall be kept current.

§23.125. Flammable and combustible materials.

(a) Combustible materials may not be located near heat sources.

(b) Flammable materials shall be used safely, stored away from heat sources and inaccessible to children.

§23.126. Furnaces.

(a) Furnaces shall be inspected and cleaned at least annually by a professional furnace cleaning company or trained maintenance staff.

(b) Documentation of the inspection and cleaning shall be maintained in the business ***???? office ????*** of the RTF. ***Word Missing?***

§23.127. Portable space heaters.

The use of portable space heaters, defined as heaters that are not permanently mounted or installed, is not permitted.

§23.128. Wood and coal burning stoves.

The use of wood and coal burning stoves is not permitted.

§23.129. Fireplaces.

(a) Fireplaces shall be securely screened or equipped with protective guards while in use.

(b) Staff shall be present with a child while a fireplace is in use.

(c) A fireplace chimney and flue shall be cleaned when there is an accumulation of creosote. Written documentation of the cleaning shall be kept.

§23.130. Smoke detectors and fire alarms.

(a) AN RTF shall have a minimum of one operable automatic smoke detector on each floor, including the basement and attic.

(b) There shall be an operable automatic smoke detector located within 15 feet of a bedroom door.

(c) The smoke detectors specified in subsections (a) and (b) shall be located in common areas or hallways.

(d) Smoke detectors and fire alarms shall be of a type approved by the Department of Labor and Industry or listed by Underwriters Laboratories.

(e) If the RTF serves four or more children or if the RTF has three or more stories including the basement and attic, there shall be at least one smoke detector on each floor interconnected and audible throughout the RTF or an automatic fire alarm system that is audible throughout the RTF.

(f) If one or more children or staff are not able to hear the smoke detector or fire alarm system, all smoke detectors and fire alarms shall be equipped so that a person with a hearing impairment will be alerted in the event of a fire.

(g) If a smoke detector or fire alarm becomes inoperative, repair or replacement shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

(h) There shall be a written procedure for fire safety monitoring if the smoke detector or fire alarm becomes inoperative.

§23.131. Fire extinguishers.

(a) There shall be at least 1 operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

(b) If the indoor floor area on a floor including the basement or attic is more than 3,000 square feet, there shall be an additional fire extinguisher with a minimum 2-A rating for each additional 3,000 square feet of indoor floor space.

(c) A fire extinguisher with a minimum 2A-10BC rating shall be located in a kitchen. The kitchen fire extinguisher meets the requirements for 1 operable fire extinguisher for each floor as required in subsection (a).

(d) Fire extinguishers shall be listed by Underwriters Laboratories or approved by Factory Mutual Systems.

(e) Fire extinguishers shall be accessible to staff. A fire extinguisher may be kept locked if access to the extinguisher by a child may cause a safety risk to the child. If fire extinguishers are kept locked, staff shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

(f) Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

§23.123. Fire drills.

(a) An unannounced fire drill shall be held at least once a month.

(b) Fire drills shall be held during normal staffing conditions and not when additional staff are present.

Comment:

The reality expressed by RTFs is that additional staff are needed following a fire drill, especially the ones that take place during sleeping hours. The addition of staff post-drill also assist in availability of scheduled staff for immediate debriefing.

(c) A written fire drill record shall be kept of the following:

(1) Date.

(2) Time.

(3) Amount of time for evacuation.

(4) The exit route used.

(5) The number of children in the RTF at the time of the drill.

(6) Problems encountered.

(7) Whether the fire alarm or smoke detector was operative.

(d) The evacuation route must allow children to evacuate the entire building into a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert, within 2 ½ minutes or within the period of time specified in writing within the past year by a fire safety expert. The fire safety expert may not be an employee of the RTF.

(e) A fire drill shall be held during sleeping hours at least every 6 months.

(f) Alternate exit routes shall be used during fire drills at least every 3 months.

(g) Fire drills shall be held on different days of the week, at different times of the day and night and on different staffing shifts.

(h) Children shall evacuate to a designated meeting place outside the building or within the fire-safe area during a fire drill.

(i) A fire alarm or smoke detector shall be set off during each fire drill.

(j) An elevator may not be used during a fire drill or a fire.

§23.133. False Alarms

An RTF shall document false alarms internally and make the documentation available for review by the Department. The frequency of false alarms should be considered as part of the overall quality assurance plan.

Comments:

It should be noted that many children learn to pull the fire alarms, and repeated instances of this behavior are really a matter for the clinical team to address, rather than the quality assurance group.

CHILD HEALTH

§23.141. Child health and safety.

(a) A child shall have a written health and safety assessment within 24 hours of admission.

(b) The assessment shall be completed or coordinated, signed and dated by medical personnel or staff trained by medical personnel as specified in an RTF training policy approved by the Department.

(c) The assessment shall include the following:

(1) Identification of strengths of the child and family.

(2) Known or suspected suicide or self-injury attempts or gestures and emotional history which may indicate a predisposition for self-injury or suicide.

(3) Known incidents of aggressive or violent behavior.

(4) Substance abuse history.

(5) Sexual history or behavior patterns that may place the child or other children at a health or safety risk.

(6) Medical information and health concerns such as allergies; medications; immunization history; hospitalizations; medical diagnoses; family history of medical problems; issues experienced by the child's mother during pregnancy; special dietary needs; illnesses; injuries; dental, mental or emotional problems; body positioning and movement stimulation for children with disabilities; and ongoing medical care needs.

(7) Trauma history.

(8) Potential medical or psychological contraindications to the use of manual restraint.

(d) A copy of the health and safety assessment shall be kept in the child's record.

Comment:

Note: terminology is different again – is it record? File?

(e) AN RTF shall develop a policy for revising and updating the health and safety assessment, which must be approved by the Department.

Comment:

"The RTF shall develop a policy for revising and updating the health and safety assessment which must be approved by the Department." Is this approval done

as part of the review approval of the overall program description or must it be a discrete policy reviewed and approved?

This seems redundant. The child health and safety plan is updated daily depending on the child's response to treatment interventions. The comprehensive discharge summary is the final updated revision. Does the Department have the capacity to approve in a timely manner all of the policies to be 'developed and approved by the Department' per the proposed regulations?

§23.142. Health and safety plan.

If the health and safety assessment in §23.141 (relating to child health and safety assessment) identifies a health or safety risk, a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed.

§23.143. Child health examination.

(a) A child shall have a health examination within 3 days after admission and annually thereafter or more frequently, as specified at specific ages in the periodicity schedule recommended by the American Academy of Pediatrics in the most current version of Recommendations for Preventive Pediatric Health Care (RE9939) available at http://practice.aap.org/content.aspx?aid=1599 .

Comment:

Starting 1-1-11, JCAHO is to allow health exams within 30 days of admission. Most providers do not have on-staff medical physicians. MOUs are often executed with local medical centers that conduct health exams. This would be an additional cost to increase the amount of physician time.

There are cost considerations specific to the three day requirement. Some RTFs have voiced concerns about payment responsibilities due to short time frame and enrollment/disenrollment practices with HealthChoices.

Are there the resources - physicians – in all areas or will RTFs need to exercise default to local ERs?

If family is to be included, scheduling may be difficult within 3 days.

(b) If a child had a health examination prior to admission that meets the requirements of subsection (e) within the periodicity schedule specified in subsection (a), and there is written documentation of the examination, an initial examination within 3 days is not required. The next examination shall occur within the periodicity schedule specified in subsection (a).

(c) If a child will participate in a program that requires physical exertion; a health examination shall be completed before the child is scheduled to participate in the physical exertion portion of the program.

Comment:

How is 'physical exertion' being defined? Health risks and restrictions should be identified in the initial health and safety assessment.

(d) The health examination shall be completed, signed and dated by a licensed physician, certified registered nurse practitioner or licensed PA. Written verification of completion of each health examination shall be kept in the child's medical record specifying the following:

(1) Date of the examination.

(2) Results of the examination.

(3) Name and address of the examining practitioner.

(4) Follow-up recommendations.

(e) The health examination shall include the following:

(1) A comprehensive health and developmental history, which includes both physical and behavioral health development and the following:

(i) The following information about the child's mother's pregnancy, if available:

(A) Use of alcohol, drugs, cigarettes, and prescribed medications during the child's mother's pregnancy and signs of fetal alcohol spectrum disorder.

(B) Complications during the child's mother's pregnancy.

(C) Child's weight at birth.

(D) Whether child's birth was early, late, or term.

(E) Type and nature of delivery and complications, if applicable.

(F) Child's mother's postpartum complications.

(G) Domestic violence victimization of the child's mother during or after pregnancy.

(ii) Developmental milestones.

(iii) Emotional complications.

(iv) Medical illnesses, injuries, surgeries, and hospitalizations.

(v) Drug allergies.

(vi) History of abuse or neglect.

(vii) Out-of-home placements.

(viii) Use of psychotropic medications and responses.

(ix) Regular or special education placement in school.

(x) Nature of special education settings, if applicable.

(xi) Psychological or educational testing and results.

(2) A comprehensive, unclothed physical examination.

Comment:

Concern is always expressed regarding this requirement and the sensitivity and professional judgment needed based on experiences of the child, especially in situations of sexual abuse/trauma.

This listing is redundant and unrealistic. The comprehensive health and developmental history is included in the initial health and safety assessment, and would not be known to the examiner anyway. This also assumes that the information is readily available when the reality is that some children come from chaotic backgrounds and/or they are not in the custody of their families.

(3) Immunizations, screening tests and laboratory tests as recommended by the American Academy of Pediatrics in the most current version of Recommendations for Preventative Pediatric Health Care (RE9939) available at http://practice.aap.org/content.aspx?aid=1599 including the following laboratory tests:

(i) CBS, differential, and platelets.

(ii) Electrolytes.

(iii) Liver function studies.

(iv) BUN and creatinine (renal).

(v) Fasting blood glucose.

(vi) Lipid profile.

(vii) Blood level if one or more of the following medications are being taken:

(A) Lithium.

(B) Depakote.

(C) Tegretol.

(D) Wellbutrin.

Comment:

This is a rigorous listing for lab work, well in excess of what is typically ordered and paid for by Medicaid.

(viii) Blood level assessments for a child under 5 years of age, unless the examining practitioner determines that the testing is unnecessary, after reviewing the results of previously conducted blood lead testing, which review and conclusion is documented in the child's medical record.

Comment:

Does this bullet make sense as a stand alone or should it be a sub-bullet of vii?

(ix) Sickle cell screening for a child who is African-American unless the examining practitioner determines that the testing is unnecessary, after reviewing the results of previously conducted sickle cell testing, which review and conclusion is documented in the child's medical record.

(4) A gynecological examination including a breast examination and a Pap test as recommended by medical personnel.

(5) Urine screen for drugs.

(6) Calculation of BMI.

(7) Communicable disease detection, if recommended by medical personnel based on a child's health status and with required written consent in accordance with applicable laws.

(8) Specific precautions to be taken if the child has a communicable disease, to prevent spread of the disease to other children.

(9) An assessment of the child's health maintenance needs, medication regimen and the need for blood work at recommended intervals.

(10) Special health or dietary needs of the child, including consideration of the child's BMI.

(11) Allergies or contraindicated medications.

(12) Medical information pertinent to diagnosis and treatment in case of an emergency.

(13) Physical or mental disabilities of the child, if any.

(14) Health education, including anticipatory guidance.

(15) Recommendations for follow-up physical and behavioral health services, examinations and treatment.

(f) Immunization records, screening tests and laboratory tests may be completed, signed and dated by an RN or licensed practical nurse instead of a licensed physician, certified registered nurse practitioner or licensed PA.

§23.144. Dental care.

(a) A child shall receive dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

(b) A child who is 3 years of age or older shall have a dental examination performed by a licensed dentist and teeth cleaning performed by a licensed dentist or dental technician at least semiannually. If a child has not had a documented dental examination and teeth cleaning within 6 months prior to admission, a dental

examination and teeth cleaning shall be performed within 30 days after admission.

(c) Follow-up dental work indicated by the examination, such as treatment of cavities and application of protective sealants, shall be provided in accordance with recommendations by the licensed dentist.

(d) A written record of completion of each dental examination, including the preadmission examination permitted in subsection (b), shall be kept in the child's record, specifying the following:

(1) Date of the examination.

(2) Dentist's name and address.

(3) Procedures completed.

(4) Follow-up treatment recommended.

(5) Dates follow-up treatment was provided.

Comment:

How is dental care paid for if child is not MA eligible and private insurance plan of parents does not include this benefit?

§23.145. Vision care.

(a) A child shall receive vision screening and services to include diagnosis and treatment, including eyeglasses, for defects in vision.

(b) A child who is 3 years of age or older shall receive vision screening within 30 days after admission in accordance with the periodicity schedule recommended by the American Academy of Pediatrics in the most current versions of "Guidelines for Health Supervision," and "Eye examination and Vision Screening in Infants, Children and Young Adults (RE9625)."

(c) If a child had a documented vision screening prior to admission that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b) an initial examination within 30 days after admission is not required. The next screening shall occur within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment and services, such as provision of eyeglasses, shall be provided as recommended by the treating practitioner.

(e) A written record of completion of a vision screening, including the preadmission screening permitted in subsection (c), shall be kept in the child's record, and include the following:

(1) Date of the screening.

(2) Treating practitioner's name and address.

(3) Results of the screening.

(4) Follow-up recommendations.

(5) Dates follow-up services and treatment were provided.

Comment:

How is vision care paid for if child is not MA eligible and private insurance plan of parents does not include this benefit?

§23.146. Hearing care.

(a) A child shall receive a hearing screening and services to include diagnosis and treatment, including hearing aids, for defects in hearing.

(b) A child who is 3 years of age or older shall receive a hearing screening within 30 days after admission in accordance with the periodicity schedule recommended

by the American Academy of Pediatrics in the most current version of "Guidelines for Health Supervision."

(c) If a child had a documented hearing screening prior to admission that meets the requirements of subsection (a) within the periodicity schedule specified in subsection (b) an initial examination within 30 days after admission is not required. The next screening shall occur within the periodicity schedule specified in subsection (b).

(d) Follow-up treatment and services, such as provision of hearing aids, shall be provided as recommended by the treating practitioner.

(e) A written record of completion of each hearing screening, including the preadmission screening permitted in subsection (c), shall be kept in the child's record, specifying the following:

(1) Date of the screening.

(2) Treating practitioner's name and address.

(3) Results of the screening.

(4) Follow-up recommendations.

(5) Dates follow-up services and treatment were provided.

§23.147. Use of tobacco.

Comment:

Child is defined as a person under 21 years of age, and Pennsylvania law permits persons 18 or older to smoke. The proposed regulation would prevent an 18 year old child from using or possessing tobacco products would seem to conflict with proposed regulation 23.33 that indicates that civil rights may not be limited.

(a) Use or possession of tobacco products by a child is prohibited.

(b) Use or possession of tobacco products by staff is prohibited in the RTF and during transportation provided by the RTF.

(c) If staff use tobacco products outside but on the premises of the RTF, the following apply:

(1) AN RTF shall have written fire safety procedures. Procedures shall include extinguishing procedures and requirements that smoking shall occur at least 100 yards from the RTF and at least 100 yards from flammable or combustible materials or structures.

(2) Written safety procedures shall be followed.

(3) Use of tobacco products shall be out of the sight of the children.

§23.148. Health and behavioral health services.

(a) AN RTF shall identify acute and chronic conditions of a child and shall arrange for or provide appropriate medical treatment.

(b) Medically necessary physical and behavioral health services, diagnostic services, follow-up examinations and treatment, such as medical, nursing, pharmaceutical, dental, dietary, hearing, vision, blood lead level, psychiatric and psychological services that are planned or prescribed for the child, shall be arranged for or provided.

§23.149. Emergency medical plan.

(a) AN RTF shall have a written emergency medical plan listing the following:

(1) The hospital or source of health care that will be used in an emergency.

(2) The method of transportation to be used.

(3) An emergency staffing plan for an emergency situation where staff counted in staff ratio are required to leave the RTF.

(4) Medical and behavioral health conditions or situations under which emergency medical care and treatment are warranted.

(b) A child's parent and, when applicable, a child's guardian or custodian, shall be given a copy of the emergency medical plan upon admission.

(c) A child's parent and, when applicable, a child's guardian or custodian, shall be notified immediately if the emergency plan is implemented for the child.

STAFF HEALTH

§23.151. Staff health statement.

(a) Staff or volunteers who come into direct contact with a child or who prepare or serve food, shall submit a staff health statement that the staff or volunteer is free of serious communicable disease that may be spread through casual contact or that the staff or volunteer has a serious communicable disease that may be spread through casual contact, but is able to work in the RTF if specific precautions are taken that will prevent the spread of the disease to children.

(b) The staff health statement must be signed and dated by a licensed physician, certified registered nurse practitioner or licensed PA within 12 months prior to working with a child or food service and every 2 years thereafter.

(c) The RTF shall follow the written instructions and precautions specified in subsection (a).

NUTRITION

§23.161. Three meals a day.

AN RTF shall provide at least three meals and one snack a day to the children.

§23.162. Quantity of food.

(a) The quantity of food served shall meet minimum daily requirements as recommended by the United States Department of Agriculture, unless otherwise recommended in writing by a licensed physician, certified registered nurse practitioner or licensed PA for a specific child.

(b) Additional portions of meals shall be available for a child.

§23.163. Food groups and alternative diets.

(a) A meal shall contain at least one item from the dairy, protein, fruits and vegetables and grain food groups, unless otherwise recommended in writing by a licensed physician, certified registered nurse practitioner or licensed PA for a specific child.

(b) Dietary alternatives shall be available for a child who has special health needs, including a need to lower BMI, religious beliefs regarding dietary restrictions or vegetarian preferences.

§23.164. Withholding or forcing of food prohibited.

(a) AN RTF may not withhold meals or drink as punishment.

(b) A child may not be forced to eat food or drink.

TRANSPORTATION

§23.171. Safe transportation.

The following requirements apply whenever an RTF, staff or volunteer provides transportation for a child. These requirements do not apply if transportation is provided ***Note: Missing word - by*** a source other than the RTF.

(1) The mental health worker-to-child ratios specified in §23.58 (relating to staff ratios) apply.

(2) A child shall be in an individual, age and size appropriate, safety device at all times when the vehicle is in motion.

(3) Restraints shall not be used routinely for transport and may only be used in the event of an emergency safety situation as specified in §§23.201 and 23.206 (relating to general information and restrictive procedure records).

(4) A driver of a vehicle shall be 21 years of age or older.

(5) Vehicles utilized for transportation of a child shall comply with local, State and Federal laws.

MEDICATIONS

§23.181. Storage of Medications.

(a) Prescription and over-the-counter medications shall be kept in their original containers.

(b) Prescription and potentially poisonous over-the-counter medications shall be kept in an area or container that is locked.

(c) Prescription and potentially poisonous over-the-counter medications stored in a refrigerator shall be kept in a separate locked container.

(d) Prescription and over-the-counter medications shall be stored separately.

(e) Prescription and over-the-counter medications shall be stored under proper conditions of sanitation, temperature, moisture and light.

(f) Discontinued and expired medications, and prescription medications for a child who is no longer served at the RTF, shall be disposed of in a safe manner.

§23.182. Labeling of medications.

(a) The original container for prescription medications shall be labeled with a pharmacy label that includes the child's name, the name of the medication, the date the prescription was issued, the prescribed dosage and the name of the prescribing physician.

(b) Over-the-counter medications shall be labeled with the original label.

§23.183. Use of prescription medications.

(a) The clinical rationale for a prescribed medication must be clearly documented in a child's medical record.

(b) A change in medication must be documented in a child's medical record.

(c) The prescribing physician shall obtain and document consent form the responsible party for medication prescribed, explaining the medication's expected effects, expected side effects, and the expected effects of withholding the medication. The responsible party is the individual who initially consented for child's treatment, including the child 14 years of age and older, the child's parent or, when applicable, the child's guardian or custodian.

Comments:

This is a major area of ethical concern to some psychiatrists. If a psychiatrist is in some way prevented from providing what he/she believes to be appropriate care, he/she has a duty to refer the patient elsewhere. They cannot allow

themselves to be placed in a position where they are giving something other than what they believe to be appropriate care.

With this regulation, DPW has taken away the option of discharging the patient whose family does not permit/support appropriate treatment.

Note also that the regulation may conflict with the child protective services law. The psychiatrist is a mandated reporter of abuse, and if he/she believes that the parent's refusal to consent treatment constitutes medical neglect, he/she is obligated to call ChildLine. This is obviously a negative consequence for parents.

This expectation for the prescribing physician to obtain consent appears to be in conflict with previous sections addressing consents to treatment. If the intent is to have the prescribing physician obtain and document consent, can this be delegated to nursing staff?

(d) Psychotropic medication orders must be written by a physician.

(e) A psychiatrist shall see a child on psychotropic medications at least every 30 days, and more frequently until the child's condition is stable, and document in the child's medical record the child's progress and clinical status.

(f) Dosage changes do not require additional consent; however, an RTF shall notify, by phone or in writing, the child's parents and, when applicable, the child's guardian or custodian, whenever dosage changes are made.

Comments:

How can this requirement be made more manageable, i.e. allow nursing staff/licensed pharmacist/others to do this, suggesting the MD be available should there be any questions.

Cost implications of dictating which staff must do this are considerable and too prescriptive.

How does this connect with self medication administration, especially for older youth, and during outings/normalization activities?

(g) The clinical rationale for a prescribed medication must be clearly documented on a child's discharge summary or final evaluation.

Comments:

This proposed regulation creates a potential ethical dilemma for a treating physician. Example: A physician employed by the provider diagnoses a child with schizophrenia. The standard of care for treatment of schizophrenia includes the use of antipsychotic medications. The physician could be found negligent for failing to prescribe such medications. In the community, when a parent refuses such a recommendation, the physician is obligated to refer the parent to another provider. A provider employee, however, retains a case on his caseload and he/she is prevented from treating that child in the appropriate manner. The only ethical options for that physician are to seek a court order (or threaten to seek a court order) or seek discharge of that client. This proposed regulation serves to create a situation in which the physician is unable to exercise his/her professional judgment, exposing themselves to considerable liability.

(h) A prescription medication shall be used only by the child for whom the medication was prescribed.

(i) A child and the child's family may not be threatened or incur negative consequences, including discharge, when they disagree with or refuse a clinical recommendation for medication.

(j) AN RTF shall put in place strategies that promote choice in medication decisions including the following:

(1) Full access to information for a child and the child's family about medications, including side effects.

Comment:

What is "full access"? Please define. What would this look like in practice?

(2) Staff who are willing and able to help a child and the child's family explore and understand the positive and negative possible consequences of taking or not taking a medication.

(3) Processes which are immediately responsive to concerns or side effects which the family or child suspect are related to the medication, including a

consult with the prescribing physician within 24 hours, or sooner if necessary.

Comment:

Include other professionals under the supervision of the physician (nurse practitioners etc.) as sources for consultation.

(4) Staff who are able to identify alternative or complementary strategies which address the areas of concern that the medication seeks to address, including relaxation and coping processes which match a child's interests, temperament, culture, and developmental levels.

Comment:

Who decides what "alternative or complementary strategies" are, what is appropriate, what is reimbursable, what are acceptable practices? These options, if truly effective and viable options, should have been tried prior to this level of care.

Liability and ethical implications are significant as are costs for staff to do this.

How will there be coordination to support a comfort level of physician/ psychiatrist with these approaches?

(k) Prescribed medications must be included on the ISP.

§23.184. Medication log.

(a) A medication log shall be kept for each child. The medication log shall be made available to members of the treatment team.

(b) A child's medication log shall include the following:

(1) A list of prescription medications.

(2) The prescribed dosage.

(3) Possible side effects.

(4) Contraindicated medications.

(5) Specific administration instructions, if applicable.

(6) The name of the prescribing physician.

(7) A list of over-the counter medications.

(c) For prescription and over-the-counter medication, including insulin administered or self-administered, documentation in the medication log shall include the medication that was administered, route of administration, dosage, date, time and the name of the person who administered or self-administered the medication.

(d) The information in subsection (c) shall be logged at the same time a dosage of medication is administered or self-administered.

§23.185. Medication errors.

(a) Documentation of a medication error shall be kept in the child's medication log. A medication error includes the failure to administer medication, administering the incorrect medication, administering the correct medication in an incorrect dosage or administering the correct medication at the incorrect time.

(b) After a medication error, follow-up action to prevent a future medication error shall be taken and documented.

Comment:

This must also be cross referenced with reportable incidents requirements.

§23.186. Adverse reaction.

If a child has a suspected adverse reaction to a medication, an RTF shall notify the prescribing physician, the child's parent and, when applicable, the child's guardian or custodian, no later than 24 hours after the suspected adverse reaction occurs.

Documentation of adverse reactions and the physician's response shall be kept in a child's medical record.

§23.187. Administration.

(a) Prescription medications, including injections, shall be administered by one of the following:

(1) A licensed physician, licensed dentist, PA, RN, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of an RN who is present in the RTF.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the RTF.

(4) A child, if the child meets the requirements in §23.188 (relating to self-administration).

(5) Staff who have completed a medication training approved by the Department under certain circumstances listed in §23.189 (relating to special circumstances).

Comments:

Why have trained staff been eliminated as alternatives for administration of medications? What is the rationale? Is there data on medication administration practices/errors that supports changing current practice?

The Department already has an extensive training program to prepare direct care staff to administer medications under the current Chapter 3800 regulations. With the current ongoing shortage of nurses, the only way some facilities can administer medications to clients is by using trained medication technicians. It is unrealistic to take this option away at this time, particularly with the difficulty in attracting nurses.

Does DPW have empirical evidence that would suggest that there is a higher medication error rate with trained direct care staff than with nursing staff? What is the rationale for imposing this change on programs (not to mention the employees who work as medication technicians) without evidence to suggest that the use of medication technicians is somehow dangerous to children is not readily apparent.

Who hands the medications to the families while on leave? This states that only those listed above can administer the meds.....

Costs related to limitations on those who can administer meds are significant.

LPNs can be employed as aides but not as MH workers and therefore cannot be counted as part of staff ratio.

Requiring that an M.D., R.N., P.A., paramedic, L.P.N., C.R.N.P. administer all medication requires additional nursing staff. In the current nursing shortage, these positions are difficult to fill. The rationale for such a requirement and consideration of the additional costs, especially to smaller programs, should be clearly justified if such a change is, in fact, absolutely necessary.

This is cost prohibitive because it would require a licensed medical professional to be on staff all waking hours to administer medications. This is also contradictory, because there is a medication training that has been approved by the Department, and those who have successfully completed the training may administer medications under 'some circumstances.

If an RTF requests a waiver to continue having staff who have completed a medication training approved by the Department administer medications under all circumstances because proven competency in medication administration does not put the health or safety of a child in jeopardy, would that waiver be granted? If the Department approves trained but unlicensed staff to administer medications in some circumstances (23.189), why not in all circumstances? What is the difference between staff who can administer medication in sleep hours vs. waking hours?

(b) A prescription medication and an injection shall be administered according to the directions specified by a licensed physician, certified registered nurse practitioner or licensed physician's assistant.

Comments:
There are significant cost implications related to the elimination of trained staff as individuals approved to administer medications.

Restricting such administration to health care professional staff will present immediate and cost prohibitive challenges to the small community based RTFs.

It will be extremely difficult to comply with recruiting, retaining and compensating nursing staff especially in more rural areas.

§23.188. Self-administration.

A child is permitted to self-administer medications, insulin injections, and epinephrine injections for insect bites, food and latex allergies, if the following requirements are met:

(1) A person who meets the qualifications of §23.187(a) (1)—(3) and (5) (relating to administration) is physically present observing the administration and immediately records the administration in accordance with §23.184 (relating to medication log).

(2) A child recognizes and distinguishes the medication and knows the condition or illness for which the medication is prescribed, the correct dosage and when the medication is to be taken.

Comment:

Self-administration of medications for older youth must be addressed in a more developmentally appropriate manner. This was an issue missed in the Chapter 3800 regulations which has never been addressed/corrected.

§23.189. Special circumstances.

Staff who have completed a medication training approved by the Department are permitted to administer medications in the following circumstances:

(1) The staff who have completed the medication administration training are accompanying one or more children away from the RTF and the person who meets the qualifications of §23.187(a) (1)—(3) (relating to administration) is not with the group.

(2) Staff who meet the qualifications of §23.187(a) (1)—(3) are not present at the RTF during sleep hours, and the medication is prescribed to be administered during sleep hours.

(3) A person who meets the qualifications of §23.187(a) (1)—(3) is unavailable do to an emergency situation caused by a natural disaster, weather related condition, or unexpected illness.

Comments:

This section sets an expectation that RTFs will still exercise discretion using only Department approved medication administration training to support appropriate responses as listed under these special circumstances. This curriculum, which has been the basis for numerous concerns shared with the Department, is an additional expense for RTF providers. In this restricted application model, it will be an expense with little benefit or opportunity to practice certified skills.

§23.190. Medication performance monitoring.

To assist in measuring the quality of care provided and outcomes achieved for a child in an RTF, an RTF shall provide a report to the Department on the following every 6 months:

(1) The number and percentage of children under 21 years of age who are receiving 3 or more psychotropic medications.

(2) The number and percentage of children under 21 years of age who are receiving 1 or more antipsychotic medications.

Comments:

This proposed regulation will require providers to provide the Commonwealth with partial information regarding psychotropic medication. Providers will be required to report numbers/percents of people on various medications, but not the reasons for such medication. Data on drug use is largely meaningless without accompanying information on diagnosis or reason for which the medication was prescribed.

A provider supporting a high percentage of children with significant Axis I disorders would certainly be expected to have a high percentage of drug use. Without diagnostic information, the counts of medications are useless yet they serve as a potential weapon that the Commonwealth could use against providers.

This section should be deleted entirely, and replaced by the requirement the provider develop and maintain a review system for the use of psychotropic medication.

RESTRICTIVE PROCEDURES

§23.201. General Information.

Comments:

This section of the regulations would have more clarity if it were re-titled as "Emergency Interventions" and re-drafted with the sections that follow thru 23.206.

Restrictive procedure is discussed, but never defined. Subsection b designates three procedures as restrictive, but leaves out numerous evidence based procedures that are generally recognized as restrictive (overcorrection, aversive consequences, token economies for people with 6400 licensed programs). A definition is needed, unless the Commonwealth considers there to be only 3 restrictive procedures and thereby permits all other such procedures.

(a) If a restrictive procedure is used, the staff who administers the procedure shall have completed training specified at §23.62(d) (relating to staff training).

(b) Restrictive procedures include time-out, restraint, and seclusion.

Comment:

This section indicates that "restrictive procedures" include "time-out, restraint and seclusion". 23-201-c indicates that "drug restraint" and "manual restraint" are the only restrictive procedures permitted in a RTF. "Time-out" is not a restraint and it is not seclusion. Perhaps it does not qualify as a restrictive procedure.

(c) The only restrictive procedures permitted in an RTF are drugs used as a restraint and manual restraint and those may be used only in an emergency safety

situation in accordance with the provisions of this chapter. If the child objects to the administration of a drug used as a restraint , which a physician has determined is needed as a result of an emergency safety situation, an RTF must have the child evaluated for inpatient psychiatric hospitalization.

Comment:

Can an RTF use time out as a treatment procedure? A clear definition of time out is needed throughout this document. (See section 23.204 for additional comments.)

The use of a time out, as perceived by some, can be child-initiated. Additional clarification is needed.

(d) A restrictive procedure may not be used in a punitive manner, as a means of coercion, discipline, retaliation or retribution, or for the convenience of staff , or as compensation for lack of staff presence or competency, or as a program substitution.

(e) A restrictive procedure shall be discontinued when a child demonstrates the child has regained self-control. Staff involved in implementing a restrictive procedure shall inform the child during the procedure, in easily understandable language, of the criteria for discontinuation of the restrictive procedure.

(f) A restrictive procedure may not result in harm or injury to a child.

Comments:

The above section indicates that "a restrictive procedure may not result in harm or injury to a child". Any restrictive procedure as an emergency intervention can have an unintended injury as an outcome. What is the purpose of the statement?

Experience has been that provider staff have been subject to inappropriate findings of child abuse for any accidental harm or malpractice that occurs.

It would seem that the effort to prevent harm might be better regulated by creating a requirement for RTFs to use only procedures that have been medically reviewed for safety.

It is naïve to think that an emergency restraint can be expected to have no possibility of harming a child. Risks are even included in restraint consent forms. The literature makes the possibility of injury quite clear.

Would it not make more sense to state that the restrictive procedure is believed to be less likely to result in harm than the failure to implement the procedure? That when used, the intent is to prevent the child from harming themselves or others?

§23.202. Restrictive procedure policy.

(a) AN RTF shall establish a policy for the use of restrictive procedures and specifically address the use of restraint as an emergency safety intervention in the policy.

(b) The policy shall address the requirements set forth in this chapter and all applicable Federal laws.

§23.203. Written plan to create a restraint-free environment

(a) AN RTF shall submit to the Department a written plan that includes goals and timeframes for establishing a trauma-informed care approach to move toward a restraint-free environment within the RTF.

Comments:

Once again, the proposed regulation attempts to impose a clinical model on the providers. Trauma informed care is not a universally accepted approach. It would be reasonable for the Commonwealth to mandate providers to develop and submit plans to reduce restraint use, but it is inappropriate to mandate that such plans must be based on the trauma informed care model. This imposition is no different than attempting to mandate that all RTFs adopt a psychoanalytic model of service. There are a variety of models, many with evidence supporting their use. The Commonwealth should not be identifying a particular model.

There have been significant debates in recent years as tot eh ability to create a restraint free environment. Even the most verbal advocates have been clear that restraint is a legitimate intervention to prevent a youth from harming themselves or others.

(b) The written plan must include:

(1) Alternative approaches to the use of restraint consistent with a trauma-informed approach and ongoing staff training on alternative approaches and trauma-informed care as specified in §23.62(d) (relating to staff training).

(2) The data that the RTF will collect and the manner in which the RTF will collect the data based on the requirements of the Department.

Comment:

Data collection based on requirements of Department? What are these requirements?

(3) Additional data the RTF has chosen to collect.

(4) The RTF's internal performance improvement process to monitor and reduce the use of restraint.

(c) The RTF shall annually review the plan to measure progress toward establishing an environment that is free from the use of restraints and restrictive procedures, modify the plan as needed, and submit any modifications for Department approval.

Comments:

This section requires the RTF to establish a written plan to create a "Restraint-Free environment". Since restraint may only be used for "emergency intervention", it seems to suggest that RTF environments will be using restraint interventions in "non-emergency situations" and therefore must become emergency-free.

Subsection (b.1.) requires that "trauma informed care" alternatives be used instead of "restraint". Trauma informed care alternatives to restraint being used in "nonemergency situations" makes sense – strategies such as "time-out", "redirection", "regrouping", "communication clarification", etc. are very appropriate for non emergency situations. However, trauma informed alternatives may not always be used during "emergency situations".

Please identify a trauma informed alternative that could be used to stop one youth who is punching another? When hysterical young ladies fight, they pull hair, scratch eyes, bite and kick. What trauma informed strategies are suggested for these "emergency situations"?

The goal of this section is to reduce restraints and restrictive procedures. If these interventions can only be legitimately used for emergencies, then the actual goal of this section might better be stated as reducing the frequency of "emergency situations". Trauma informed strategies are most commonly used prior to "emergency situations". This is to prevent trauma-prompted behavior from escalating into an emergency situation.

It is worth noting that "Trauma" information can and should be used even when "emergency" strategies are employed. There are restrictive procedures that may be more or less appropriate depending on an individual's history. Whenever possible, emergency strategies should have a treatment orientation. This is particularly true with Self Injurious Behavior incidents. For example "cutting" behavior and "head-banging" behavior require different responses.

What are consequences if providers do not meet plan expectations? What are the criteria for the plan? What are the DPW requirements? Who reviews/ approves the plan?

Providers offer support for compliance demonstrating effective treatment approaches, a plan to eliminate restraints, alternative approaches but only when the state completes and provides data and resources to support this requirement as proposed to eliminate all restraints.

Are there expectations for individual child specific restraint reduction plans?

What is envisioned as an annual review of plan and measure progress to an "environment free from the use of restraints and restrictive procedures"?

The RTF regulations provide numerous positive guidelines on "emergency interventions" that will benefit both consumers and providers. When the pages on the program issues in the document are counted, almost twenty per cent is devoted to "emergency interventions". Were the level of specificity applied to this area the same for other program topics, the document would be an A to Z treatment on residential care. One important area that is treated

lightly in the proposal is suicide training and intervention - requirements here are less than needed. Child and adolescent suicide attempts result in many more tragic outcomes than restraint and seclusion interventions.

CMS rules regarding restrictive procedures are Federal mandates that have existed for sometime. While the process they require to initiate and implement an emergency procedure provides safeguards that help to ensure appropriate practice, they present another problem. Emergencies occur in real time. Intervention in emergency situations, where "harm to self or others" is occurring, cannot wait for "permission". Staff who are "professionally trained" can make good decisions. They should be empowered to intervene and held accountable for the intervention.

§23.204. Time out.

Comment:

In 23.201.c, time out was excluded from the list of permitted interventions, but here is an entire section on the use of time out. Clarification is needed

(a) Time out is used as intervention to provide a child with a period of time in a designated quiet area, such as the child's room or a place away from the area of activity or other child, for the purpose of providing the child an opportunity to learn how to gain self-control.

Comment:

This proposed regulation is revision of a generally accepted definition and intent of time out. The correct name of time out is time out from positive reinforcement, and it entails sending a child to an area of reduced reinforcement.

It is essentially an unpleasant consequence to a behavior that is administered with the hope of reducing the future probability of the behavior that preceded it. Nothing in the original research on time out suggested that it offered a child an opportunity to learn to gain self control. It was a means with which to reduce reinforcement, and thereby reduce the future probability of undesired behaviors.

What is described in this definition might be better called 'taking a break' or 'therapeutic regrouping'.

(b) A child may request time out, or staff who notices a change in a child's behavior that the child has not identified but appears to be escalating, or has escalated, to loss of self-control may ask a child to take time out to retain or regain self-control and function in a more positive manner.

Comment:

Under the definition offered as a comment above, a child cannot really request time out. A child can request a break or request the opportunity to go somewhere to calm down, but this is not time out.

(c) Time out may not be used in a punitive manner or for the purpose of excluding a child from general activities.

Comment:

Once again, the regulation fails to understand the traditional definition/use of time out.

(d) Staff shall monitor a child while the child is in time out and record in the child's record the following:

(1) The date and start and end times of the time out.

(2) The reason for the time out, including whether it was requested by the child.

(3) The name of the staff that monitored the time out.

(4) The resolution of the time out, including whether it was or was not successful and the reason for the success or lack of success.

Comment:

Whether time out was successful at the conclusion of the time out period cannot be determined. The success of time out can only be judged in a longitudinal manner, by looking at target behavior data over time. If each aggressive act is followed by brief time out, and if the rate of aggression is declining, time out is successful. That is the only way to ascertain success of time out.

(5) The signature of the monitoring staff.

(c) A child in time out may never be physically prevented from leaving the area where the time out is taking place.

(d) If a child is not permitted to leave the time out area, the intervention ceases to be a time out and is considered seclusion.

§23.205. Emergency safety intervention.

Comments:

This section is titled "Emergency Safety Intervention" and includes a variety of prohibited strategies, e.g. mechanical, seclusion, prone, etc. Throughout this section the terms "emergency intervention", "restraint" and "restrictive procedures" are used interchangeably. This causes confusion.

The section continues with high specificity regarding intervention orders, implementation and documentation, all of which set in motion burdensome documentation processes for the RTFs. Perhaps the Department could develop a checklist and single documentation form to assist in this and to ensure some consistency in data collection across the field. Were this done, the regulation would simply have indicated that the Department would provide a process checklist and documentation form with tasks that must be completed for all emergency interventions as per federal CMS rule.

(a) Mechanical restraints.

(1) Mechanical restraints are prohibited.

(2) The following devices are not considered mechanical restraints:

Question:

Are mechanical restraints permitted to permit healing? For example, some physicians will order helmets or mitts to permit an open wound to heal. Once healed, the devices are no longer permitted. Such actions were consistent with the 3800 regulations. Is such use permitted under these proposed regulations?

(i) A device used to provide support for functional body position or proper balance.

(ii) A device used for medical treatment, such as sand bags to limit movement after medical treatment.

(iii) A wheelchair belt that is used for body positioning and support.

(iv) A helmet used for prevention of injury during seizure activity.

(v) A seatbelt used during transportation.

(b) Seclusion.

(1) Seclusion is prohibited.

(2) Seclusion does not include the use of a time out room as defined in this chapter.

(3) Locking a child in a bedroom during sleeping hours is considered seclusion.

(c) A permissible restraint may only be used:

(1) To ensure the safety of a child or others during an emergency safety situation.

(2) After every attempt has been made to anticipate and de-escalate the behavior using methods of intervention less than restraint.

(d) Efforts to calm and de-escalate a child should continue even after a restraint is implemented, with the goal of shortening the time needed to maintain the restraint.

Comment:
efforts to calm and de-escalate a child should continue even after a restraint is implemented are contrary to current training (TCI) and will need to be addressed.

(e) The following interventions are prohibited:

(1) A restraint that applies pressure or weight on a child's respiratory system.

(2) Prone position restraints.

(3) Drugs used as restraint to control acute, episodic behavior that restricts the movement or function of a child, except for the administration of drugs ordered by a licensed physician and administered by licensed/certified/registered medical personnel on an emergency basis.

(4) The application of startling, painful or noxious stimuli, also referred to as adversive conditioning.

Comment:

"Adversive" is an incorrect term. The correct term is "aversive." Exclusion of adversive (sic) events is contained within the emergency safety intervention section of the proposed regulations. Most literature on the use of aversive stimulation incorporates it as part of a planned clinical intervention. Is such non-emergency use of aversive stimulation also precluded?

(5) The application of pain for the purpose of achieving compliance, except pressure at a child's jaw point for the purpose of bite release, also referred to as pressure point techniques.

(f) Orders for the use of restraint as an emergency safety intervention.

(1) Prior to ordering and applying a manual restraint, information and history must be obtained about potential medical or psychological contraindications to the use of manual restraint for a child. This information must be documented in a child's record and accessible to staff working with the child, including an individual who might order a restraint as an emergency safety intervention.

Comment:

According to the regulation, each application of restraint must be ordered. This is unrealistic. Even if a person with the authority to authorize a restraint were on

grounds when a restraint was required, how long would it take to get them to the situation so that they might assess and issue an order? The essence of this type of situation is emergency – It means that one cannot wait for 5-10 minutes for the physician to show up and confirm that it was an emergency.

There will be no attitude to allow a restraint to begin and then secure the order/verbal order in emergency situations.

(2) Manual restraint shall be ordered only by one of the following:

(i) The child's treatment team physician, if available.

(ii) If the child's treatment team physician is not available, one of the following, if permitted by the RTF:

(A) Another physician.

(B) If another physician is not available, a certified registered nurse practitioner or PA. Documentation that a physician was not available must be entered in the restraint log and the child's medical record.

(C) If the individuals specified in clauses (A) and (B) are not available, a licensed psychologist, licensed social worker, or licensed clinical social worker. Documentation that individuals specified in clauses (A) and (B) were not available must be entered in the restraint log and the child's medical record.

(3) If neither the treatment team physician nor one of the alternative individuals specified in paragraph (2) (ii) is available in the RTF at the time of the emergency safety situation, a verbal order for restraint may be obtained from an individual specified in paragraph (2) by an RN or

licensed practical nurse (LPN). If an RN or LPN is not in the RTF, a licensed occupational therapist or physical therapist may accept a verbal order for restraint from an individual specified in paragraph (2).

(i) The individual who ordered the restraint must be available to staff for consultation, at least by telephone, throughout the period of restraint.

(ii) A verbal order must be verified by the individual who order the restraint in the child's record.

(4) When a restraint is ordered by someone other than the child's treatment team physician, the treatment team physician shall be contacted and informed about the use of restraint by the individual who ordered the restraint no later than 24 hours after the restraint was ordered.

(5) An order for a restraint shall be entered into a child's record by the ordering individual.

(6) An order for restraint must include the following:

(i) The name of the ordering physician or other individual specified in paragraph (2) (ii).

(ii) The date and time the order was obtained.

(iii) The specific type of restraint ordered, including length of time for which the order authorized the restraint.

(iv) The reason the restraint was ordered.

(v) The frequency and duration that staff shall monitor the child's vital signs.

(7) The physician or other individual specified in paragraph (2) (ii) shall order the least restrictive restraint likely to be effective in resolving the emergency safety situation taking into account onsite-staff recommendations.

(8) An order to administer a drug used as a restraint must meet the following requirements:

(i) The drug is ordered by a licensed physician.

(ii) The drug is administered by a licensed, certified or registered medical professional.

(iii) The child is examined by a licensed physician immediately prior to each incidence of administering a drug and the licensed physician has given a written order to administer the drug immediately prior to each incidence of administering a drug.

(9) An order for restraint must:

(i) Be limited to no longer than the duration of the emergency safety situation. A standing or PRN order for restraint is prohibited.

(ii) Under no circumstances exceed 2 hours for a child between 18 and 21 years of age, 1 hour for a child between 9 and 18 years of age, and 30 minutes for a child under 9 years of age.

(10) If the restraint is discontinued before the original order expires, a new order must be obtained prior to reapplying the restraint.

Comment:

This regulation may have the impact of prolonging restraint. Staff are instructed to attempt to release so that a child is restrained no longer than necessary.

Sometimes, the attempt to release is made too quickly and the child must be restrained a second time. To require a second order may create a contingency in which staff are punished by attempting to release a client. They are punished in that they have to seek and get a second order. They could perceive it to be much easier simply to continue the restraint.

(g) Application of restraint.

(1) Only staff trained in the use of emergency safety interventions as specified at §23.62 (staff training) shall be permitted to apply a restraint.

(2) During a restraint the these trained staff shall:

(i) Continually access and monitor the physical and psychological well-being of the child.

(ii) Release the hold by changing the position of the physical restraint or the staff applying the restraint at least once every 10 consecutive minutes during the restraint.

(iii) Ensure the safe use of restraint throughout the duration of the restraint and assess both physical and psychological factors of the child.

(iv) Clearly identify for the child the criteria for discontinuation of the restraint.

(v) A restraint will be discontinued when a child demonstrates the child has regained self-control.

(3) During a restraint, staff trained in the use of restraint, but who are not applying the restraint, must continuously observe, monitor, and document the physical and emotional condition of the child. Staff must document the

condition of the child at least every 10 minutes after the restraint begins in the child's record.

Comment:

How are staff supposed to monitor vital signs on a struggling client during a restraint? Is this even possible? Monitoring color and respiration is feasible, but it is difficult to get temperature, blood pressure, and other traditionally defined vital signs on a person being restrained.

(4) The use of the restraint must be limited to the duration of the emergency safety situation and until the child's safety and the safety of others can be ensured, even if the order for restraint has not expired.

(5) If the emergency safety situation continues beyond the time specified in the order authorizing the restraint, an RN or other licensed staff, must contact the individual specified in subsection (f)(2)(ii) to receive further instructions.

(6) During a restraint, a child's physical needs shall be met.

(7) During the use of a drug as a restraint, staff shall monitor the child's vital signs at least once an hour and in accordance with the frequency and duration recommended and documented by the prescribing physician, in addition to the requirements in paragraph (2).

(8) Within 1 hour of the initiation of the restraint, a physician, certified registered nurse practitioner, RN or PA trained in the use of emergency safety interventions and permitted by the RTF to assess the physical and psychological well-being of children must conduct a face-to-face

assessment of the physical and psychological well-being of the child including:

(i) The child's physical and psychological status.

(ii) The child's behavior.

(iii) The appropriateness of the intervention measures.

(iv) Complications resulting from the intervention.

Comment:

This regulation seems to preclude the use of LPNs to do body checks. This may be a little unrealistic in light of the nursing shortage.

It is not clear how a medical person, who may only slightly know the child, is best equipped to do a psychological evaluation of a child. In fact, one could argue that for an RN to do this is acting outside of their area of professional competence.

(h) Medical treatment for injuries resulting from the use of restraint.

(1) Staff shall assess a child to determine the extent of any injuries and shall obtain medical treatment from qualified medical personnel for a child injured as a result of a restraint immediately after discovery of an injury. Staff that is medically trained to provide emergency first-aid care and cardiopulmonary resuscitation should be available during and after a restraint to provide emergency medical interventions until further follow-up care can be provided.

(2) Staff that applied or participated in a restraint that results in an injury to a child must meet with supervisory staff and evaluate the circumstances that

caused the injury, and the RTF must develop a plan to prevent further injuries.

Comment:

Staff that participated in a restraint that results in injury must meet with supervisor and develop a plan. However, this incident would be called into ChildLine, and therefore can not be immediately investigated internally.

(i) Notification of parent and, when applicable, the guardian or custodian.

(1) AN RTF shall notify a parent and, when applicable, the guardian or custodian, of a child who has been restrained as soon as possible, but no later than 5 hours after the initiation of the restraint.

Comment:

Notifying the parents within five hours may be unreasonable. Some parents are unreachable; others are at work and cannot take phone calls. Some parents do not want to be notified of each restraint.

How can an RTF respond to parental request for restraint summaries on a weekly or monthly basis only?

One must also consider that sometimes restraints occur in the middle of the night. If a restraint occurs at 12:30AM, should the family be called in the middle of the night to advise them of a restraint, or would it be more reasonable to wait for the next day?

(2) AN RTF shall document in a child's record that the parent and, when applicable, the guardian or custodian, has been notified of the restraint, including the date and time of notification and the name of the staff providing the notification.

(j) Documentation of restraint.

(1) Documentation of a restraint must be written in a child's medical record and shall include the following:

(i) A description of the emergency safety situation.

(ii) The order for restraint as specified in subsection (f)(7).

(iii) If an individual specified in subsection (f)(2)(ii) ordered the restraint, an explanation that other staff were unavailable, as specified in subsection (f)(2)(ii).

(iv) For verbal orders, the name and title of the individual ordering the restraint, the time the order was given, the type of restraint ordered and the maximum time for which the restraint was ordered. The licensed staff identified at subsection (f) (3) accepting the verbal order shall sign and date the orders received. The ordering individual shall counter sign the order within 1 business day of the restraint.

(v) The time the restraint actually began and ended.

(vi) The names and job titles of staff involved in the restraint.

(vii) The time and results of the 1 hour assessment, specified in subsection (g)(8).

(viii) The date and time the treatment team physician was contacted and informed about the use of restraint, if the restraint was ordered by someone other than the treatment team physician.

(ix) Other documentation listed at §23.206(b) (relating to restrictive procedure records).

(x) The dates, times and methods of attempts to notify a child's parent and, when applicable, the guardian or custodian, and the date and

time of successful notification signed by each individual that attempted to contact the parent and, when applicable, the guardian or custodian.

(xi) A summary of each post-intervention debriefing.

(xii) A description of all injuries that occur as a result of the restraint, including injuries to staff resulting from restraint.

(2) AN RTF shall maintain a record of each emergency safety situation, the restraints used, and their outcomes.

(k) Post-Intervention debriefings.

(1) Shortly after the restraint is discontinued, staff involved in the restraint and supervisory staff shall conduct an informal and brief post-release debriefment with the child for the purpose of rebuilding trust, helping the child regain composure, and briefly discussing how the restraint might have been avoided and can be avoided in the future. If a child requests that the child does not want a particular staff who was involved in the restraint to participate in the post-release debriefment, that request must be honored.

Comment:

Is debriefing to be a witch hunt or an honest search for how the restraint could have been avoided. It seems that no one in DPW is appreciative of the risk to direct care staff in participating in a debriefing that is monitored or led by an administrator. If that staff acknowledges that perhaps he/she should not have implemented a restraint, is that any different than an admission of client abuse? The administrator present will have no choice but to file child abuse charges and the staff will ultimately lose his/her job.

Under these circumstances, how likely is it that staff will participate in an open, honest, and constructive manner? They need some sort of protection, whether it

is a grant of immunity or the guidelines that the meeting be conducted absent management staff. It seems unrealistic to hope that direct care staff will be honest in a situation that places their employment in jeopardy. Perhaps it would be simpler to just fire any staff who implements a restraint.

With rotating schedules of staff, getting all staff together with the client within 24 hours may be impossible. Because of the imperative to supervise all of the children in the program, there is little way this sort of meeting could be held without incurring substantial overtime costs.

Is there a possibility that this meeting will be perceived by the child as a group of adults ganging up on him/her? Why do all of the staff need to be involved? Wouldn't it work just as well to have a clinician meet with the child in a timely manner to review the incident?

The focus on restraint reduction as a target is misguided. The focus should be on promoting client behavior change, and thereby eliminating the need for restraint use.

(2) Within 24 hours after the restraint is discontinued, staff involved in the restraint, except when the presence of particular staff may jeopardize the well-being of the child, shall meet face-to-face with the child to discuss the circumstances that resulted in the use of restraint and strategies to be used by the staff, the child, or others that could prevent the use of restraint in the future.

(i) Other RTF staff, the RTF Family Advocate, ISPT members, the child's parents and, when applicable, the guardian or custodian, shall be given the opportunity to participate in the meeting.

(ii) If the child's parents and, when applicable, the child's guardian or custodian, attends the meeting, the RTF must conduct the meeting in a language that is understood by the child's parent and, when applicable, the guardian or custodian.

(3) Within 24 hours after the restraint is discontinued, staff involved in the restraint, appropriate supervisory and administrative staff, and the RTF Family Advocate shall conduct a debriefing session that includes, at a minimum, a review and discussion of the following:

(i) The emergency safety situation that required the restraint, including discussion of the participating factors that led up to the restraint.

(ii) Alternative techniques that might have prevented the use of the restraint.

(iii) The procedures, if any that staff are to implement to prevent any recurrence of the use of restraint.

(iv) The outcome of the restraint, including any injuries that may have resulted from the use of restraint.

(4) Staff shall document in the child's record that all 3 debriefing sessions took place. The documentation must include the following:

(i) The name of staff present for the debriefings.

(ii) The name of staff that were excused from the debriefings.

(iii) Changes to the child's treatment plan that result from the debriefings.

Comment:

There is no reference made to new state statute prohibiting use of restraint with pregnancy women in labor.

The expectation that there be a third debriefing following every restraint is overly-burdensome and is more restrictive that the CMS federal rules governing restraints.

A separate record of each use of restrictive procedure is to be kept. All incident reports are kept in the child's clinical record. To have to maintain separate records for every restraint again is overly burdensome. Most providers maintain a database for all incident reports and see no value to adding a third record keeping mechanism.

§23.206. Restrictive procedure records.

(a) A central record of each use of restrictive procedure shall be kept and shall include the following:

(1) The specific behavior addressed.

(2) The methods of intervention used to address the behavior, including all less intrusive measures attempted, and the reasons these measures were not effective.

Comment:

Defining reasons that less restrictive approaches failed to work is a challenge unless the Commonwealth will accept as reason that the child continued to assault others/harm themselves.

(3) The date and time the procedure was used.

(4) The specific procedure used.

(5) The staff that used the procedure.

(6) The duration of the procedure.

(7) The staff who observed the child during the procedure.

(8) The child's condition upon completion of the procedure.

(9) The order for restraint.

(10) The time and results of the required 1-hour assessment.

(11) The physician or other licensed practitioner who order the restraint shall sign the restraint order in the record as soon as possible.

Comment:
This section indicates that the order needs to be signed ASAP but 23.205 j 1 iv states that it is to be documented within 1 business day.

(b) Documentation of compliance with this section shall be kept in the child's record.

SERVICES

§23.221. Description of services.

(a) AN RTF shall operate its program and provide services in accordance with a written service description approved by the Department.

(b) The service description must include the following:

(1) The RTF location, legal ownership, and administration table of organization.

(2) The vision and mission of the RTF.

(3) A detailed description of how the program will meet the requirements in this chapter and current clinical standards of care.

(4) The scope and a general description of the services provided by the RTF.

(5) The number, ages, needs, and any special characteristics of the children the RTF serves.

(6) Specific activities and programs provided by the RTF.

(7) Staff qualifications and staffing ratio's with explanations for those that exceed the minimum requirements.

(8) Explanation of the RTF's ability to support and maximize the quality of life and functional abilities of children with emotional and behavioral issues using gender-responsive approaches that includes a continuum of out-of-home treatment options for children with behavioral health needs.

(9) Demonstration of the RTF's ability to address special characteristics of the children the RTF intends to serve including neurological disability such as autism spectrum disorder (ASD or a co-occurring disorder such as substance abuse or disability such as developmental delay, deafness, and blindness.

(10) A written policy regarding staff filing legal charges against a child which includes the following:

Comments:

While it is generally counterproductive to file charges against children in residential treatment, it must be recognized that staff have the absolute right to press charges.

An RTF can discourage staff from taking this action because it tends to have absolutely no positive impact, but it remains the right of staff to take the meaningless action.

Providers should not be required to commit to writing a policy that in some way limits employee rights in this area.

Assaults on staff are frequent, and having a policy that in any way would formally discourage the exercise of staff rights appears to be counter productive.

Further, having a policy and teaching this policy to staff might actually result in an increased number of police reports because we will have inadvertently empowered staff to report client behavior to the police.

(i) The nature of the emotional and behavioral needs of the children residing at the RTF.

(ii) The possibility for injury to staff because of the potential of aggressive behaviors to occur as a result of the clinical conditions of a child.

(iii) A procedure for staff that choose to press charges to inform RTF management and discuss the pros and cons of pressing charges with the RTF director, with documentation of the meeting and meeting outcomes prior to filing charges.

(11) Verification from the LEA of the school district in which the RTF is located stating the following:

(i) The RTF has consulted with the LEA and the LEA has acknowledged its obligation to educate a child who is in an RTF in the most integrated setting and in the public school, whenever appropriate.

(ii) The LEA will meet the education, special education, and related service needs of the children in the RTF.

(iii) AN RTF shall notify the LEA if the RTF plans to expand or make other changes that will impact the LEA's requirement to provide educational services.

Comment:

There should not be an expectation that these polices will be incorporated within the actual service description. Education laws to cover this.

The RTF cannot mandate the LEA of a school district to do anything, including that they provide verification of consultation, or their obligation to educate. The RTF cannot mandate the LEA to meet the education needs of the child in the RTF – that mandate is issued and monitored by the Department of Education.

(c) The service description and policies and procedures must be approved by the Department before the RTF begins operation.

(d) A change to an approved service description, which includes a change in the number of children the RTF plans to serve and to any approved policy or procedure, must be approved by the Department prior to implementation.

Comment:

Throughout this proposed Chapter there are number of references to policies to be approved by the Department. These polices may be reviewed as attachments to the service description but there should not be an expectation that these polices will be incorporated within the actual service description.

§23.222. Admission process.

(a) Prior to admitting a child, an RTF shall interview the child and determine if its services, activities and programs are appropriate for the age, needs, and any special characteristics of the child. The RTF shall document its findings. If the RTF determines that its services, activities and programs are not appropriate for the child and the child should not be admitted to the RTF, the RTF shall explain to the referral source in writing the reason the child cannot be admitted to the RTF. The RTF must maintain the documentation in the business office of the RTF for periodic review by the Department.

Comment:

Are the BHMCOs aware of this proposed requirement to interview? This could be very costly and time consuming

How will this affect the response time/admissions decision?

How will findings need to be documented?

If an RTF agrees to interview and declines, how does this fit within a "no eject/no reject" expectation?

How long must records be maintained? Why in the business office and not administrative bldg?

(b) The RTF shall have an admission process that assesses and documents the following for a child, prior to or upon admission:

(1) A child's diagnosis.

(2) Results from a structured screening or assessment.

Comment:

Structured screening or assessment of what?

(3) The service needs of a child.

(4) A child's legal status.

(5) Circumstances that make admission of a child necessary.

(6) Results of a trauma screen administered upon admission or within 7 days of admission with a summary of findings and a discussion of the clinical relevance of the findings to the child's presenting problems. If the RTF has a copy of a trauma screen administered to the child within the prior 4 months, then the RTF does not need to administer another screen, but must include a written discussion of the findings of the earlier trauma screen and the clinical relevance of those findings to the child's presenting problems as required.

Comment:

Is there a recommended trauma screen tool to be used in first 7 days?

(7) Summary of a strengths and culture discovery or assessment completed upon admission or within 7 days of admission.

Comment:

What is a strengths and culture discovery assessment?

(8) How the activities and services provided by the RTF will address the biopsychosocial needs of a child.

(c) AN RTF shall retain documentation of the prior approval of the administrator of the Interstate Compact on the Placement of Children in the record of a child admitted from outside of the Commonwealth of Pennsylvania.

(d) If a child is readmitted to the same RTF within 5 days, the readmission will not be considered a new admission for MA program purposes, but rather a continuation of the original admission.

§23.223. Development of the ISP.

(a) A preliminary treatment plan addressing a child's behavioral health needs shall be completed within 24 hours of admission.

(b) An ISP shall be developed for a child within 14 calendar days of a child's admission and must include the following:

(1) A comprehensive strengths-based treatment plan addressing the behavioral health needs of a child and based on a diagnostic evaluation and the information related to a child's trauma screen and history demonstrating that trauma-related factors are being addressed in clinical treatment.

(2) Medical needs of a child, including medications.

(3) Psychological, social, behavioral and developmental needs of a child that reflect the need for RTF admission.

Comment:

This practice does not follow what the literature supports as best practice. Many social service/trauma professionals argue that assessments should/must take

many weeks and any intervention prior to this is premature (much less developing a plan).

This is also in direct contrast to the fact that most children within RTF "honeymoon" for 2-4 weeks and any plan written from this time period could assume that the child has mastered skills that are in fact still deficient.

The RTF does not know a child well enough to develop a comprehensive plan in 14 days. Ideally, the parent or other significant adult would be involved in the development of a treatment plan. However, for many children served this is not the case as Foster parents may no longer be involved and CYS worker is not able to provide details of behavioral issues needed for an ISP.

14 days is far too brief of a period upon which to base an ISP. It would require the professionals to attempt to conduct assessments prior to the child's stabilization in the program. The child may be in a honeymoon period, or he/she may be in a state of depression or some sort of trauma associated with being removed from his/her family. To borrow from the state's vocabulary, to require the ISP to be developed within 14 days may not reflect trauma sensitive treatment.

(c) The ISP shall be developed by an ISPT, an independent team comprised of the following:

(1) The child.

(2) The child's parents and, when applicable, the child's guardian or custodian.

(3) A person invited by the child or the child's parent.

Comment:

What is required to make sure this person is present? What if they opt out?

(4) A contracting agency representative.

(5) A representative of the county Mental Health/Mental Retardation Program.

(6) A prescribing or treating psychiatrist or other clinician who will be working with the child.

(7) A representative of the CCYA or JPO if the child is in the child welfare or juvenile justice system.

(8) A child's Behavioral Health MCO.

(9) A representative of the responsible school district if written parental consent has been obtained.

(10) A physician.

Comments:

Can be on team but not necessarily present for the meetings? Unrealistic to get this entire team together in one room, especially the BHMCO.

Are all these necessary for each child or is it as applicable?

It seems like the required team is loaded with people who will actually be working with the child. What about the psychologist, teacher, nurse, occupational therapist, speech therapist, program specialist, and residential counselor?

The composition of the ISPT is unrealistic if it is expected that a physician will attend.

The prescribed ISPT does not include the family advocate.

(d) The treatment plan portion of the ISP addressing a child's behavioral health needs must be developed by the treatment team, which must be an interdisciplinary team of physicians and other personnel who are employed by, or provide services to children in, the RTF.

(1) The treatment team shall:

(i) Assess a child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and limitations.

(ii) Assess the potential resources of a child's family.

(iii) Set treatment objectives.

(iv) Prescribe therapeutic modalities to achieve a plans objective.

(2) The treatment team must include a board-eligible or board-certified psychiatrist and one of the following:

Comment:
This requirement is contradictory and cost prohibitive. The listed positions are not part of the staffing requirements previously outlined in these proposed regulations, and would be considered additional staff outside of what has already been prescribed.
Using already prescribed staff for treatment meetings would take them out of ratio or would take them away from prescribed responsibilities incurring additional costs for additional staff and/or overtime.

(i) A psychiatric social worker.

Comment:

What is a psychiatric Social Worker? Need definition as this is not a commonly referenced title/term.

(ii) An RN with specialize

d training or one y ear of experience in treating children with a serious mental illness or emotional or behavioral disorder.

(iii) A licensed occupational therapist who has specialized training or one year of experience in treating children with a serious mental illness or behavioral disorder.

(iv) A psychologist who has a master's degree in clinical psychology or who has been licensed by the Commonwealth of Pennsylvania.

Comments:

These requirements are viewed as being cost prohibitive.

(e) At least 3 phone or written contacts shall be made at least 2 weeks in advance to invite the child and the child's parent and, when applicable, a guardian or

custodian, to participate in the development of the ISP at a time and location convenient for the child and the child's parent, and when applicable, the child's guardian or custodian, and the RTF.

Comment:

If reached the first time, are 3 phone/written contacts necessary? Should only be 3 if not reached at first.
Three contacts two weeks in advance to invite parent/guardian to development of the ISP at a time and location convenient to them and the requirements stated in 23.223 b that the plan needs to be developed within 14 days would require that all of these contacts would need to be made the day of admission .

(f) Documentation of a contact made to involve a child's parent and, when applicable, guardian or custodian shall be kept in the child's record.

(g) Persons who participated in the development of the ISP shall sign and date the ISP, with the exception of the child, the child's parent and, when applicable, the child's guardian or custodian, who shall be given the opportunity to, but are not required to, sign the ISP. Disagreement with the ISP or refusal to sign the ISP shall be document in the child's record.

§23.224. Content of the ISP.

An ISP should reflect the needs, strengths, culture, and priorities of a child and the child's family, and shall include the following:

(1) A treatment plan that is written in language understandable to the child and the child's family, and includes the following:

(i) Developmentally appropriate, asset-building treatment goals and objectives, such as building functional competencies.

(ii) Biologic, psychologic and social interventions.

(iii) The child's identified priorities.

(iv) The environments in which the child exhibits a behavioral health treatment need.

(v) An explanation of the appropriate settings and time allocations for an intervention.

(vi) A detailed description of changes or updates from previous treatment plans.

Comment:

Previous treatment plans as completed within this RTF?

(vii) Documentation of the continued clinical need for the service.

(viii) Detailed information to assist the staff with a comprehensive understanding of the specific interventions and objectives with which the staff will be assisting a child in attaining goals.

(2) Evaluation of the child's skill level for a goal.

Comment:

What is this? What assessment used? Additional clarity is needed.

(3) Monthly documentation of the child's progress on each goal.

Comment:

Every 30 days (not monthly) corresponds with psychiatric review timeframes.

(4) Services and training that meet the child's needs, including the child's needs for safety, competency development and permanency.

(5) A component addressing family involvement including, when applicable, the collaborative efforts with a high-fidelity wraparound team.

(6) A plan to teach the child health and safety skills including the following:

(i) Nutrition and food selection.

(ii) Exercise.

(iii) Physical self-care.

(iv) Sleep.

(v) Coping skills.

(vi) Relaxation approaches.

(vii) Personal interests for constructive use of leisure time.

(viii) Substance use and abuse.

(ix) Personal safety.

(x) Healthy interpersonal relationships.

(xii) Services to others.

(xiii) Decision-making skills.

Comment:

This list is highly prescriptive and may not be appropriate for all children served.

(7) A component addressing how a child's education needs will be met in accordance with applicable Federal and State laws and regulations.

(8) The anticipated duration of the stay at the RTF.

(9) Discharge and aftercare plan to be addressed during monthly treatment team meetings and during ISPT meetings to ensure continuity of care with a child's family, school, and community upon discharge.

(10) Methods to be used to measure progress on the ISP, including who is to measure progress and the objective criteria to be use.

(11) The name of the person responsible for coordinating the implementation of the ISP.

(12) Medical needs, including medication.

Comments:

The detailed prescriptive nature of this section of the proposed regulation is restrictive and does not allow for clinical focus or specialization. The prescriptive elements, while appearing to be specific, are in fact unclear, i.e., (ii) biologic competencies?, (iii) child's identified priorities (what if the child's priorities are to drop out of school and become pregnant)? (4) services and training that meet the child's needs (training for whom?) (5) family involvement (is this the family involvement plan? The family participation plan?)

§23.225. Review and revision of the ISP.

(a) A review of a child's progress on the ISP, and a revision of the ISP if needed, shall be completed at least every 30 days.

Comment:

A revision of the ISP every 30 days is an extreme increase in the frequency. This has significant impact in costs (both in the meeting time of the team members and the time to write and distribute the treatment plan).

More importantly, this contradicts what is known about how children change. Behaviors and mental illness that have developed over the course of years do not typically alter significantly in the course of a month. Children take time to consolidate and assimilate new strategies and then alter behavior.

Updating ISPs at this frequency will not improve treatment but rather take time away from direct client care and produce reports that are virtually identical in nature. Agencies already do an update of progress (or lack there of) on a monthly basis which is provided to families and other agencies involved in the child's treatment.

(b) A child's ISP shall be revised if one of the following occur:

(1) There has been no progress on a goal.

(2) A goal is no longer appropriate.

(3) A goal needs to be modified.

(4) A goal needs to be added.

(c) A review and revision of the ISP shall be completed in accordance with §23.223 (b)(i) (relating to development of the ISP.)

(d) AN RTF shall notify and invite a child's parents and, when applicable, a guardian or custodian, to participate in the review of the ISP and consider making changes based on a child's clinical course. Parent, and when applicable, guardian or custodian involvement is also to be obtained for a change in type of psychotropic medication.

(e) A child and the child's parent and, when applicable, guardian or custodian, shall contribute to the development, review, and revision of a child's ISP.

§23.226. Implementation of the ISP.

(a) AN RTF shall implement an ISP as written.

(b) AN RTF is responsible to assign sufficient staff responsible for the implementation of the ISP, including the treatment plan.

§23.227. Copies of the ISP.

(a) A copy of an ISP, revisions to an ISP, and monthly documentation of progress shall be provided to the child if the child is over 14 years of age, the parent and, when applicable, the child's guardian or custodian, the contracting agency, and a person who participated in the development of or revision to the ISP.

Comments:

In what format are they to be provided?

What about confidentiality of the client and therapy issues?

This conflicts with prior notice of who can review the record.

(b) A copy of an ISP, revisions to an ISP, and monthly documentation of progress shall be kept in the child's record.

§23.228. Behavioral health treatment.

(a) AN RTF shall provide behavioral health treatment that is build on the competencies of a child and the child's family, while addressing specific needs of the child including culture, treatment history, and family relationships.

(b) Behavioral health treatment shall include, at a minimum, the following, which shall be provided as needed:

(1) Individual psychotherapy, group psychotherapy, family therapy, and other therapeutic interventions, using evidence-based approaches, when possible, as indicated in the treatment plan, which addresses both the child's presenting behaviors and underlying mental health issues and, when clinically indicated, co-occurring issues to include mental health and substance abuse.

Comments:

Delete the phrase "when possible" where used in reference to evidence based treatments. As noted earlier, the only acceptable forms of treatment are evidence based and experimental (with appropriate experimental design and data collection). There should be no option to permit the use of 'treatments' that lack evidence supporting their efficacy.

(2) Alternative approaches for a child when individual or group psychotherapy modalities are not considered effective treatment approaches, such as with a child with ASD, alternative approaches must be used.

(3) Both resiliency-promoting therapeutic milieu and trauma-informed care, characterized by supporting dignity, respect, and hope**, as part of both individual and group programming that includes the following:

(i) Community meetings.

(ii) Pro-social peer groups.

(iii) Psychoeducation groups.

(4) Social skills consistent with a child's successful adaptation to both society norms and a child's individual community.

(5) Age-appropriate training about maintenance of good physical health including, with the permission of a parent and, when applicable, a guardian or custodian, the prevention of sexually transmitted diseases including HIV/AIDS.

Comment:

Is parental permission needed for this education?

(6) Special individualized activities, relevant to a child's medical or physical needs.

(7) Use of psychotropic medication, when indicated.

(8) Training in daily living skills and community access skills.

§23.229. Education.

(a) Under 22 Pa.Code Chapters 11, 14 and 15 (relating to student attendance; special education services and programs; and protected handicapped students), a child who is of compulsory school age shall participate in a school program

approved by the Department of Education or an educational program under contract with the LEA.

(b) The decision regarding the education portion of a child's day is to be made on an individualized basis utilizing the most integrated setting, with input from members of the ISPT, local public education officials and the child's home school district.

Comment:
Educational requirements are developed and monitored by the Department of Education.

Decision regarding education needs to include the role and authority of the parent/guardian.

§23.230. Discharge and aftercare planning.

(a) A child's discharge and aftercare planning shall occur at a treatment team meeting and must be child centered and incorporate the following:

(1) Short-term goals, such as participation in a sport, community activity or religious organizations.

Comment:

Goals must be individualized.

(2) Long-term life goals, including attainment of independent living and vocational skills and other special skills, such as playing a musical instrument or attending post-secondary education.

(3) For a child receiving or who has received psychotropic medication during the child's RTF stay, a psychiatric discharge summary or final evaluation.

(b) Prior to discharge, the RTF shall schedule an appointment with the community behavioral health agency that will provide aftercare and submit documents related to the child's care in the RTF to that behavioral health agency.

Comment:

RTFs are typically responsible for making clinical recommendations for discharge and aftercare services. The ICM/BSU/MH/MR staff are charged with making appointments and arranging services based on the recommendations made by the RTF and are responsible for making sure the aftercare services are occurring as recommended.

(c) Within 14 days prior to discharge, the RTF shall submit the discharge summary to the community behavioral health agency providing aftercare.

Comment:

It will not be a complete discharge summary if it is done 2 weeks ahead.

(d) For each child receiving or who has received psychotropic medication during the child's RTF stay, the clinical rational for psychotropic medication shall be clearly documented on the child's psychiatric discharge summary or final evaluation.

(e) Prior to the transfer or discharge of a child, the RTF shall inform, and discuss with the child's parent and, when applicable, the child's guardian or custodian, the recommended transfer or discharge. Documentation of the discussion or transmission of the information shall be kept in a child's record.

(f) No later than 10 days after discharge, if a child was placed in the RTF by another state, the RTF shall document in the child's record that the administrator of the Interstate Compact on the Placement of Children was notified of the discharge.

(g) AN RTF shall follow up with a child and family by telephone, 15 and 30 days post-discharge to determine if the child is receiving community-based behavioral health services, as identified in the discharge and aftercare plan.

(h) If, as a result of the RTF telephonic contact at 15 or 30 days post-discharge with a child and family, the RTF learns that a child is not receiving community-based behavioral health services, the primary contact or other designated staff, with child and family consent, shall contact the community-based behavioral health provider, the county MH/MR office, or the CASSP Coordinator to facilitate the provision of the community-based behavioral health services. The outcome of this telephonic contact must be documented in a child's record.

Comment:

This regulation makes the inaccurate assumption that the child is always a Pennsylvania resident and scheduled to receive services through the Pennsylvania system. The various offices listed in the proposed regulation will not pertain if the child lives in New Jersey.

CHILD RECORDS

§23.241. Emergency information.

(a) Emergency information shall be easily accessible at an RTF and documented in a child's record.

(b) Emergency information for a child shall include the following:

(1) The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.

(2) The name, address and telephone number of the child's physician or other source of health care, health insurance, and Medical Assistance information.

(3) The name, address and telephone number of the person able to give consent for medical treatment, if needed.

(4) A copy of the child's most recent health examination.

§23.242. Child records.

(a) A separate record shall be kept for a child.

(b) Entries in a child's record shall be legible, dated and signed by the person making the entry. The record shall be maintained in an organized and competent manner.

§23.243. Content of child records.**

A child's record shall include the following:

(1) Personal information including:

(i) Name, sex, admission date, birth date and Social Security Number.

(ii) Race, height, weight, color of hair, color of eyes and identifying marks.

(iii) Dated photograph of the child taken within the past year.

(iv) Language spoken or means of communication understood by a child and the primary language used by a child's family, if other than English.

(v) Religious affiliation.

(vi) Emergency information required by 23.241(b) (relating to emergency information).

(2) Physical health records.

(3) Dental, vision and hearing records.

Comment:

In how much detail? Record of visits or actual dental records that dentists keep?

(4) Health and safety assessments.

(5) Behavioral health evaluations during the course of treatment, including psychiatric evaluations, psychological evaluations, and psychological testing results, if obtained.

(6) ISP and ISP revisions and summaries of ISP reviews.

(7) Restrictive procedure records relating to the child as required by §23.206 (relating to restrictive procedure records).

(8) Reports of reportable incidents, as specified in §23.17 (relating to reportable incidents).

(9) Consent to treatment, as specified in §23.20 (relating to consent to treatment).

(10) A court order, if applicable.

(11) Admission information specified in §§23.221 and 23.222 (relating to description of services; and admission process).

(12) Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in §23.31 (relating to notification of rights and grievance procedures).

(13) Service records of the contracting agency.

(14) Education records.

(15) Current treatment plans.

(16) Past treatment plans.

(17) Special consultations or assessments completed or requested.

(18) Progress notes that document a child's participation in individual therapy, group therapy, family therapy, and other therapeutic interventions.

(19) Documentation of a child's progress toward meeting treatment goals.

(20) Documentation of the family's participation in planning and treatment and ongoing efforts of the RTF to accommodate family schedules and encourage participation.

(21) Current psychotropic medication and documentation of regular medication reviews and the clinical rationale for the psychotropic medication including the following:

(i) A change in medication documented in a medication order.

(ii) Documentation of the administration of a prescribed medication, including dosage, route of administration, staff administering, and signature of staff administering.

(22) Documentation of goals of therapeutic leave and the outcomes and reviews following therapeutic leave.

Comment:

Therapeutic leave is not included in the definitions but is referenced here. Is it allowed?

§23.244. Record retention.

(a) A child's record shall be kept in a locked location when unattended.

(b) Information in a child's record shall be kept for at least 6 years or until an audit is final or litigation is resolved.

(c) A child's record shall be kept for at least 6 years following a child's discharge or until an audit is final or litigation is resolved, whichever is later.

RTFS SERVING NINE OR MORE CHILDREN

§23.251. Additional requirements.

In addition to the other provisions of this chapter, sections 23.251—23.257 apply to an RTF serving nine or more children.

§23.252. Sewage system approval.

AN RTF that is not connected to a public sewer system shall have a written sanitation approval for its sewage system by the sewage enforcement official of the municipality in which the RTF is located.

§23.253. Evacuation procedures.

Written emergency evacuation procedures and an evacuation diagram specifying directions for egress in the event of an emergency shall be posted in a conspicuous place.

§23.254. Exit signs.

(a) Signs bearing the work "EXIT" in plan legible letters shall be placed at an exit.

(b) If the exit or way to reach the exit is not immediately visible, access to an exit shall be marked with readily visible signs indicating the direction of travel.

(c) Exit sign letters shall be at least 6 inches in height with the principle strokes of letters at least ¾ inch wide.

§23.255. Laundry.

(a) There shall be a laundry area which is separate from kitchen, dining, and other living areas.

(b) Soiled linen shall be covered while being transported through food preparation and food storage areas.

§23.256. Dishwashing.

(a) Utensils used for eating, drinking, preparation and serving of food or drink shall be washed, rinsed and sanitized after each use by a mechanical dishwasher or by a method approved by the Department of Agriculture.

(b) A mechanical dishwasher shall use hot water temperatures exceeding 140°F in the wash cycle and 180°F in the final rinse cycle or shall be of a chemical sanitizing type approved by the National Sanitation Foundation.

(c) A mechanical dishwasher shall be operated in accordance with the manufacturer's instructions.

§23.257. Child bedrooms.

A child's bedroom may not be more than 200 feet from a bathtub or shower and toilet.

Comment:

There are no references to Secure RTFs. Is this because there is a change in policy as to accreditation being necessary? Will the requirements for them be addressed separately?

Subchapter B. PARTICIPATION REQUIREMENTS

SCOPE OF BENEFITS

§23.281. Scope of benefits.

(a) A child who is an MA recipient is eligible for medically necessary RTF services provided by an RTF enrolled in the MA Program.

(b) A child who is receiving services in an accredited RTF the day preceding the date of the child's twenty-first birthday continues to be eligible for RTF services until RTF services are no longer medically necessary or the individual is 22 years of age, whichever occurs first.

§23.282. Policy.

(a) The Department pays for medically necessary services rendered to an eligible individual, as specified in §23.281 (relating to scope of benefits), by an RTF enrolled in the MA Program.

(b) Payment in the fee-for-service delivery system is made for services provided by an RTF subject to the provisions of this chapter and Chapter 1101 (relating to general provisions).

(c) Payment in the managed care delivery system is made for services provided by an RTF subject to the provisions of this chapter and Chapter 1101, except that the Department may delegate responsibilities to the behavioral health managed care organizations as specified in section 23.318 (relating to Department delegation of responsibility to behavioral health managed care organizations).

(c) Payment for absence without authorization.

(1) The Department will make payment for up to 2 days of absence without authorization from an RTF when the following conditions are met:

(i) Upon determining that a child is absent without authorization an RTF shall file a police report and notify the JPO if the child has one. The RTF shall also conduct a search of the RTF buildings, grounds and off-site areas where the staff believes the child might have gone.

(ii) If a child cannot be located within 2 hours of the initial determination that the child is missing, the RTF must notify the following:

(A) The County MH/MR Office.

(B) The CCYA, if the child is in its custody.

(C) The supervising juvenile court, if the child is under the supervision of the juvenile court.

(D) The child's responsible family member of legal guardian, as appropriate.

(iii) AN RTF must search off-site for at least 4 hours during each 24-hour period that the child is absent without authorization.

(iv) When the child is found or returns voluntarily, the RTF must notify previously notified parties that the child is no longer absent without authorization.

(v) An action taken to locate the child during the child's absence without authorization and the required notifications shall be documented in the child's medical record. Documentation of on-site and off-site searches must specify the date and hours of

search, where the search was conducted, any pertinent findings, and be signed by staff that conducted the search.

(2) If the child is readmitted to the same RTF within 5 days, the readmission will not be considered a new admission for program purposes but, rather, a continuation of the original admission.

PROVIDER PARTICIPATION

§23.291. General participation requirements for an RTF.

(a) The Department will regulate participation in the MA program and may refuse to allow an RTF to participate in the MA program. Before allowing enrollment, the Department will consider the MA Program's need for additional RTF services in the RTF's primary service area as the most important factor in determining whether to grant or deny a request for enrollment as an RTF.

Comment:

What is the relationship of this section to the HealthChoices BH-MCO decisions and development of their provider networks?

(b) In addition to the participation requirements established in Chapter 1101 (relating to general provisions), to participate in the MA Program, an RTF shall:

(1) Be licensed by the Department as an RTF under this chapter.

(2) Have a service description approved by the Department.

(3) Provide the services described in the service description at the location stated in the service description.

(4) Have in effect a utilization review plan that meets the requirements set forth at 42 CFR Part 456, Subpart D (relating to utilization control: mental

hospitals) and provide psychiatric services that meet the requirements of 42 CFR Part 441, Subpart D (relating to inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs).

(5) Be in compliance with Federal restraint and seclusion requirements and attest annually by July 21 of each year that the facility is in compliance with 42 CFR Part 483, Subpart G on a Department specified form. A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

(6) Have a transfer agreement with an acute care hospital and inpatient psychiatric hospital.

Comment:

This regulatory expectation is contrary to CASSP principles and BH-MCO member choice principles. These transfer agreements assume options that do not consider child/family choice, availability, whether facilities are participants with BH-MCO/other insurers, etc.

RTFs only make clinical recommendations but do not arrange for services, especially prior to family and team consultation.

(7) Receive and maintain accreditation as a child and adolescent RTF by CARF, COA, JCAHO or by another accrediting body approved by the Department as published in a notice in the ***Pennsylvania Bulletin.***

(8) Provide services under the direction of a board-certified or board-eligible psychiatrist.

(9) Meet all ISP requirements as specified in §23.223 (relating to development of the ISP).

(10) Meet all prior authorization and certification of need requirements as specified in §23.314 (relating to evaluations and treatment plans).

§23.292. Participation requirements for an out-of-state RTF.

An out-of-state RTF shall meet the following requirements:

(1) Be licensed and participate in the Medicaid Program of the state in which the RTF is located, if that state recognizes facilities which provide equivalent services.

(2) Have a service description that meets the requirements in this chapter.

(3) Have a ban on prone restraint.

(4) Meet the requirements established in Chapter 1101 (relating to general provisions) and §23.291(b)(2)—(8) (relating to general participation requirements for an RTF).

§23.293. Participation requirements for an RTF that treats children for drug and alcohol diagnosis in conjunction with a diagnosed mental illness or serious emotional or behavioral disorder.

AN RTF that treats children for drug and alcohol conditions shall:

(1) Meet the requirements established in §23.291 (relating to general participation requirements for an RTF).

(2) Be licensed by the Department of Health to provide drug and alcohol treatment services, unless the RTF contracts with a licensed drug and alcohol agency to provide substance abuse treatment services.

(3) Comply with the Department's current requirements for co-occurring competent service provision found at www.pa-co-occurring.org, including

universal screening and assessment for co-occurring disorders, referral protocols for appropriate interventions, the employment of qualified professionals to treat co-occurring disorders, and certification as a co-occurring competent RTF.

§23.294. Ongoing responsibilities of an RTF.

In addition to the ongoing responsibilities established in §1101.51 (relating to ongoing responsibilities), an RTF shall:

(1) Comply with State and Federal regulations, statutes, policies and procedures.

(2) Maintain current agreements with general and psychiatric hospitals, community-based mental health services, drug and alcohol services and, to the extent necessary, other RTF's for the prompt and appropriate transfer or referral of a child who requires or may be expected to require care in another setting.

(3) Furnish complete and accurate copies if requested of a child's records and the RTF's fiscal records to the Department or its designees, or Federal and State reviewers within 14 days of the request, unless a different timeframe is specified in the request.

(4) Retain complete, accurate, legible and auditable clinical, medical and fiscal records as specified at §23.244 (a) and (b) (relating to record retention).

(5) Notify the Department of a program site change.

(6) Submit a new attestation that the facility is in compliance with 42 CFR Part 483, Subpart G (relating to condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21) when RTF management changes.

(7) Notify the Department of the RTF's plans for the orderly transfer of children within 5 days of notification from the Department of Health that it has determined that the RTF is out of compliance with 42 CFR Part 483, Subpart G (relating to condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services for individuals under age 21) and must close.

§23.295. Changes of ownership or control.

(a) If an RTF changes ownership and the new owner wishes to participate in the MA program, the RTF shall submit a new application on the form provided by the Department for participation in the MA program.

(b) When an RTF changes ownership, the Department will approve participation in the MA Program by the new owner if the Department determines the new owner to be eligible to participate in the MA program as described under §23.291 (relating to general participation requirements for an RTF). The new ownership must meet federal and State requirements prior to approving the change.

Subchapter D. PAYMENT PROVISIONS

PAYMENT FOR RTF SERVICES

§ 23.301. Allowable Costs.

Comments:

There are significant conflicts between service requirements and allowable costs. This must be resolved.

There is a need for clear communication and access to the information used by the Department in the process of making determinations as to what are truly allowable costs elements.

The role of the BH-MCOs and assurances that BH-MCOs will be required by the Department to begin rate negotiations from a service cost level must be imposed by DPW in HealthChoices contracts.

It will be essential for the Department to create a reality-based relationship between annual costs reflected in cost reports and the per diem rate paid by the Department or BH-MCO.

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.

(a) Allowable costs.

(1) A facility's allowable costs incurred in providing services on the ISP are considered in the allocation of costs to the MA Program for its eligible recipients.

(2) Total allowable costs of an RTF shall be apportioned between third-party payors so that, within the limits of this subchapter, the share borne by the Department is based upon those actual services and costs related to children who are MA recipients.

Comment:

(a)(b) There is no need to apportion RTF costs between third-party payers. The computation of a total per diem allowable cost is applicable to all payers. Thus, this reference is unnecessary.

(3) AN RTF is responsible for the accounting of all costs and services.

Miscellaneous costs shall be documented and justified to the Department.

Comment:

(a)(c) "Miscellaneous costs shall be documented and justified to the Department." Not sure what this comment means. An RTF would have to "justify" each individual cost? How? What is materiality threshold? What is defined as "miscellaneous"?

(b) Determination of allowable costs.

The Department will determine allowable costs in accordance with the following:

(1) The requirements of this subchapter.

(2) For items not specifically identified in this subchapter, the Medicare cost report requirements fount at 42 CFR 413 and the Medicare Provider Reimbursement Manual (HIM-15).

(3) For items not specifically identified in this subchapter, the Medicare cost report requirements found at 42 CFR 413 and the HIM-15, Generally Accepted Accounting Principles (GAAP).

(c) Administrative costs.

(a) 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.

(b) Administrative costs shall be apportioned as general administration or allocated to other cost centers.

(c) General administrative costs are limited to 13% of the total MA eligible costs less general administrative costs and less depreciation and interest on capital indebtedness.

Comment:

(c)(c) The administrative cost limitation is flawed. First, it represents a reduction from previous guidance which allowed administrative costs to be 13% of total costs, effectively representing 15% of direct costs. This proposal is to reduce the allowance to 13% of direct costs, excluding depreciation and interest. Providers cannot accept this reduction, particularly in an environment of increased compliance requirements.

Administering RTF programs is getting harder, not simpler. Additionally, excluding capital costs from this base implies there is no "administrative" cost associated with these items. Clearly, they require administration as well: the original acquisition of the assets, coordination with banks or other borrowers, maintenance of accounting records, etc. Alternatively, a provider could just rent assets, which is not excluded from this definition. If buying an asset is better economically, or more practical, than leasing, why would the Department create a disincentive for it?

The administrative cost limitation is incredibly restrictive and represents a considerable reduction in allowable costs from current regulations and from those employed by most other systems (ODP, Education).

(d) Allowable administrative costs include the following:

(i) Compensation, fringe benefits and payroll taxes of the RTF's director, controller, purchasing agent, personnel director, and other persons performing general supervision or management duties.

(ii) License fees, association dues, legal costs, including attorney's fees if the provider prevails; management fees, and advertising.

Comment:

(c)(d)(ii) License fees should not be an administrative cost. They are a direct cost of operating a program.

(iii) Costs associated with the provision of supporting services such as bookkeeping, accounting, data processing, and auditing.

(iv) Costs of space used for administrative purposes, including depreciation and interest or rental.

(v) Purchase of supplies and equipment used for administrative purposes.

(vi) Operating costs associated with administrative purposes, such as travel and communications.

Comment:

(c)(d)(vi) Administrative costs should include travel and communications for administrative staff and services. Those costs applicable directly to program services and staff, as well as maintenance and other support services, should be included in those cost centers and not as administration.

(vii) Costs associated with the owners, officers or operators of the facility in accordance with the following:

(A) The salary or compensation cost of owners, officers, operators or persons other than RTF's staff only if their time and involvement is documented, and they are involved in the management of the RTF.

(B) The allowable cost for an owner, officer, operator or person other than RTF staff who are involved in the management of the RTF may not exceed the customary compensation and fringe benefits that a staff would receive if staff performed the work.

(vii) Other costs incurred for a common or joint purpose and are associated with supportive activities necessary to provide the services to children.

(d) Compensation and staffing costs.

Comments:

(d)(a) Providers take issue with the language "combined prevailing Commonwealth salaries and benefits for functionally equivalent positions..." We would suggest the Commonwealth staff responsible for enforcing these provisions have no idea what the full cost of benefits for Commonwealth employees actually is. In reality, it is probably in the 40-50% of salaries range, more than double the RTFs they will be evaluating. Given this difficulty, providers are concerned they will focus solely on salaries (thereby assuming benefits are comparable), which makes for a significantly unbalanced comparison.

It is very difficult to determine if two positions, one in the Commonwealth and one at a private provider, are "functionally equivalent". And, even if they were found to have similar job descriptions, what if the private provider had two people performing tasks for which the Commonwealth utilized three people? The private provider may pay a higher salary, but ultimately is achieving greater efficiency.

(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).

(b) Personnel costs for services that are not provided through salaried complement for the provision of necessary services for an MA recipient are allowable. Contracts that specify the nature of the service and define the unit and cost of the service shall be maintained by the facility, in addition to detailed documentation of services rendered.

(e) RTF maintenance expenses.

(a) Costs necessary for the establishment, operation and maintenance of the RTF certification and license are allowable to the extent that the maintenance costs do not duplicate costs of services performed by staff.

(b) Maintenance service contracts shall specify the nature and cost of the service in order to be allowable.

(c) Detailed documentation of maintenance service contracts shall be maintained by the RTF with all documentation of services rendered in order to be allowable.

(f) Unit-of-service contracts.

Costs associated with unit-of-service contracts where a payment is made for each service unit rendered are allowable if the following conditions apply:

(a) Units-of-service for which costs are claimed have been delivered.

(b) The unit-of-service arrangement is more economical and efficient than other contractual relationships.

(c) Services do not duplicate those provided by staff.

(g) Cost of drug services.

Comment:

(g) (c) This section addresses drug services, i.e., non-prescription drugs, as being allowable if based on a physician's written order. This does not appear to be reasonable for providers. Cold medicines, Tylenol, for example, are general over-the-counter medicines that would only be given if needed by the youth. Would not a physician be providing "health care", which is identified as an unallowable cost in Section § 31.305 (11) (a), to "prescribe" such medicines?

(a) Drug services costs for medically necessary over-the-counter drugs are allowable.

(b) Detailed and itemized documentation of the claimed expense for drug services must be maintained.

(c) Drug services costs are allowable for a non-prescription drug such as laxatives, aspirin, and antacids if the drug is provided directly to an MA recipient from the RTF's own drug supply, the drug is prescribed by a physician's written order, and is medically necessary.

(d) Payment for prescription medication will be made to an enrolled pharmacy and costs related to prescription drugs that are non-compensable under the MA Program are not considered as allowable costs for an RTF.

(e) The RTF shall not solicit or receive any remuneration directly or indirectly in cash or in kind from a person in connection with the furnishing of drugs or in connection with referring a recipient to a person for the furnishing of drugs.

(h) Staff development and training costs.

Costs associated with staff development and training costs are allowable if the training and development are associated with the requirements for each level of staff in the approved service description as described in § 23.221.

(i) Depreciation allowance.

(a) Depreciation on capital assets used to provide compensable services to children, including assets for normal, standby or emergency use, and

specialized equipment such as wheelchairs, is allowable as specified in this subsection.

(b) AN RTF will be reimbursed for allowable depreciation costs only if the RTF is the recorded holder of legal title of the capital asset or specialized equipment.

Comment:

(i)(b) Allowing depreciation only on assets to which the RTF holds legal title would exclude depreciation on leasehold improvements, which does not make sense and is inconsistent with the allowance for depreciation on leasehold improvements referenced in (i)(h)(10) - see separate comment below.

(c) AN RTF shall use the straight-line method of depreciation. Other methods, such as the accelerated method of depreciation are not acceptable.

(d) The amount of annual depreciation shall be determined by first reducing the cost of the asset by any salvage value and then dividing by the number of years of useful life of the asset.

(i) The useful life may be shorter than the physical life depending upon the usefulness of the particular asset to the RTF.

(ii) A useful life may not be less than the relevant useful life published by the Internal Revenue Service or the Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association for the particular asset on which the depreciation is claimed.

(e) Depreciation expense for the year of acquisition and the year of disposal is computed by using either the half-year or actual time method of

accounting. The number of months of depreciation expense may not exceed the number of months that the asset was in service. If the first year of operation is less than 12 months, depreciation is allowed only for the actual number of months in the first year of operation.

(f) The method and procedure, including the assigned useful lives, for computing depreciation shall be applied from year-to-year on a consistent basis and may not be changed, even if the facility is purchased as an ongoing operation.

(g) For depreciation to be allowed for an RTF that previously did not maintain fixed asset records as required in paragraph (14) and did not record depreciation in prior years, the RTF shall use the straight-line method of depreciation for the remaining useful life of the asset. The depreciation shall be based on the cost of the asset at the time of original purchase or construction. Depreciation may not be taken on an asset that would have been fully depreciated if it had been properly recorded at the time of acquisition.

Comments:

(i)(h)(10) Generally accepted accounting principles (GAAP) require leasehold improvements to be depreciated over the shorter of the lease term or useful life of the asset. This provision requires an RTF to violate these principles. It would also create a disincentive to make improvement to such properties since the RTF could be stuck with a material unrecovered cost at the end of a lease. This could compromise the ability to provide safe operating environments for the children served.

(i)(h)(11) This provision should be struck. There is no basis for "depreciation recapture" in the form of offsetting gains on assets sold by the RTF, particularly when losses aren't allowed. GAAP is very clear that depreciation accounting does not seek to measure the diminution in value of an asset during its useful life. Rather, it is a method by which the cost of using an asset in the provision of goods or services is allocated to the periods of that use, effectively matched to the related revenue generated. GAAP clearly indicates depreciation is a process of allocation, not valuation. An RTF must have a facility to provide services to its residents. That facility has an associated capital cost of operation. The reimbursement rules should be designed to allow a "use cost" of that facility, equal to the depreciation computed in accordance with AHA Guidelines. If the Department reimburses such depreciation over the life of the assets, it received what it was paying for – the use of the assets. It should have no financial interest in the asset itself as implied by this provision.

Additionally, two further thoughts on this topic:

1. The RTF made the investment in the asset, not the Department. Thus, the RTF should solely enjoy the benefit (or bear the risk) of future changes in asset valuation.

2. This provision could provide an incentive to RTFs to lease facilities, or transfer existing facilities to entities not connected to the services the Department funds. If direct acquisition of the assets by the RTF is the most economic approach, why would the Department create a disincentive for such investment?

(h) Depreciation on an RTF that has no fixed asset records and is sold will be allowed to the extent to which the prior owner would have been allowed.

(10) Leasehold improvements shall be depreciated over the useful life of the asset.

(11) Gains on the sale of fixed and movable assets are considered to be equal to the salvage value which shall be established prior to the sale of the item. Gains on the sale of fixed and movable assets shall offset allowable costs for the period in which the gain was realized. Losses incurred on the sale or disposal of fixed or movable assets will not be reimbursed under the program.

(12) Allowable depreciation will be calculated using the cost basis of an asset, determined as follows:

(i) The cost basis of the depreciable assets of an RTF that are acquired as new shall be the purchase price of the asset.

(ii) The cost basis of the depreciable assets of an RTF that are acquired as used, shall be computed by the following method:

(A) The cost basis is the lower of the purchase price or the fair market value.

(B) Fair market value is the lowest of two or more bona fide appraisals at the time of sale.

Comment:

(i)(h)(12)(ii)(B) There should be a materiality threshold for this provision. Securing "two or more bona fide appraisals" for a used vehicle is certainly not practical or cost effective.

(C) Depreciation that was taken or could have been taken by all prior owners shall be subtracted.

(D) Costs incurred during the construction of an asset, such as architectural, consulting, and legal fees, interest, and fund raising shall be capitalized as part of the cost of the asset.

(iii) If an asset is acquired by a trade-in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt as consideration paid.

Comment:

(i)(h)(12)(iii) This provision is also inconsistent with GAAP. A trade-in should be viewed as two separate transactions: 1) the sale / trade-in of the old asset; and 2) acquisition of a new asset. GAAP requires a gain or loss to be computed on the trade-in and the new asset to be recorded at its pre-trade in price. This would produce a slightly different answer than what this provision requires.

(iv) Donated assets shall be recorded at the current appraisal value or the lower of the following if available:

(A) The construction cost.

(B) The original purchase price.

(C) The donor's original purchase price.

Comment:

(i)(h)(12)(iv) Donated assets should be recorded at the appraised value at the time of the donation. All the language after the word "value" in the first line should be deleted. It is impractical and, frankly, irrelevant. The RTF should not have to burden the donor with digging up his/her original purchase price. The economic value to the RTF, and consequential benefit to the Department, is what the asset is worth at the date of gift, which would also be what the RTF would have to spend in the market to acquire a comparable asset.

(v) The cost basis for depreciable assets of an RTF transferred between related parties shall be the net book value of the seller at the date of the transfer in order for the related depreciation to be allowed.

(vi) The cost basis for depreciable assets of a facility acquired through stock purchase will remain unchanged from the cost basis of the previous owner in order for the related depreciation to be allowed.

Comment:

(i)(h)(12)(vi) and (vii) Both of these provisions should be deleted as they are inconsistent with GAAP and would create a disincentive toward merger or other forms of partnering by agencies. There could be cases where such a merger is advantageous to the Department and it should not create a disincentive.

(vii) The cost basis for depreciable assets of an RTF purchased in types of transactions other than those specified in subparagraphs (ii)—(iv) and (viii) may not exceed the seller's basis under this subchapter, less all depreciation that was taken or could have been taken by all prior owners.

(viii) The cost basis for depreciation on any asset the ownership of which changes shall be the lesser of the remaining allowable cost basis of the asset to the first owner of record or the allowable cost basis to the new owner; however, the cost basis shall exclude costs, including legal fees, accounting and administrative costs, travel costs, or the cost of feasibility studies, attributable to the negotiation or settlement of the sale or purchase (by acquisition or merger) for which the MA Program previously made payment.

(13) The reasonable cost of depreciation will be allowed for the construction and renovation of buildings to meet applicable Federal, State or local laws and building codes.

(14) Allowable depreciation must be documented in a fixed asset record that includes all of the following:

(i) Depreciation method used.

(ii) Description of the asset.

(iii) Date the asset was acquired.

(iv) Cost of the asset.

(v) Salvage value of the asset.

(vi) Depreciation cost.

(vii) Estimated useful life of the asset.

(viii) Depreciation for the year.

(ix) The accumulated depreciation.

(15) Depreciation cost is not allowable for assets expensed under another State or Federal payor.

(j) Interest.

(a) Necessary and proper interest on capital and current indebtedness is allowable.

(b) AN RTF will be reimbursed for allowable interest on capital indebtedness with respect to an asset only if the facility is the recorded holder of legal title of the assets involved.

Comment:

(j)(b) The reference to legal title should be deleted as it would not allow for the financing of leasehold improvements.

(c) Allowable interest on capital indebtedness shall not exceed the amount that a prudent borrower would pay. Interest on capital indebtedness will not be considered prudent if the provider cannot demonstrate that the rate does not exceed the rate available from lenders in the Commonwealth to similar borrowers on the date of the loan commitment.

(d) To be considered allowable, the interest expense shall be incurred and paid within 90 days of the close of the cost reporting period on a loan made to satisfy a financial need of an RTF and for a purpose reasonably related to providing services to children.

Comment:

(j)(d) The reference to payment within 90 days of the close of the cost reporting period should be deleted. Tax exempt bonds, for instance, typically require interest payments semi-annually only. Why would the Department care how a financial institution or other party requires the RTF to pay interest?

(e) Necessary interest on capital indebtedness applying to mortgages, bonds, notes, or other securities on the property and plant of the RTF will be allowed subject to the limitation of the amount recognized for depreciation purposes. The total value of mortgages, bonds, notes, or other securities on which interest on capital indebtedness is allowed may not exceed the depreciation basis of the assets.

(f) Investment income shall be used to reduce allowable interest expense on capital and current indebtedness unless the investment income is from one of the following:

Comment:

(j)(f) How can an RTF would reasonably segregate investment income into these various categories? Such reserves may have built over many years. The fact that they exist and may have been generated from services totally unrelated to the Department should not be relevant.

Additionally, under loan agreements (and due to implementation of solid business practices), an Organization may have requirements to maintain certain levels of liquidity. This is especially true when customers are governmental agencies who may not pay bills for an extended period of time (see PA budget for

FY 09-10). These requirements should not preclude the RTF from borrowing for specific needs of the RTF, with interest on such borrowings an allowable cost.

(i) Gifts, donations and grants that are not restricted by the donor for payment of allowable costs.

(ii) Funded depreciation if the interest earned remains in the funds.

(iii) AN RTF's qualified pension fund if the interest earned remains in the fund.

(iv) Interest income from gifts, if the funds on which the interest is derived are not commingled with funds that offset allowable costs.

(v) Fund-raising efforts.

(g) Investment income that reduces allowable costs, including income on operating capital, shall be used to reduce interest expense on capital indebtedness first, and then used to reduce non-capital indebtedness.

Comment:

(j)(g) Recommended that entire provision be stricken.

(h) Interest expense shall be allowable if paid on loans from an RTF's donor-restricted funds, the funded depreciation account, or the RTF's qualified pension fund. The upper limit on allowable interest may not exceed the prime interest rate charged at the time funds are borrowed.

Comment:

(j) (h) Strike entire provision, including item (10) and replace with: "Interest on inter-company loans (i.e., from the Organization's endowment or other source) should be allowable so long as the RTF can demonstrate the arrangement is equal to or more favorable than the arrangement that can be secured in the financial market."

(9) Moneys borrowed for the purchase or redemption of capital stock will be considered as a loan for investment purposes, and the interest paid on those borrowed funds is not an allowable cost.

(10) Interest expense on funds borrowed for capital purchases are not allowable until all funds in the RTF's funded depreciation account are fully expended.

(k) Rental costs.

Comment:

This entire section, related to rental costs, is way too cumbersome. Maintaining a fair market rental appraisal for all rental properties is just not practical. The requirement in (k) (i) to update them annually is ridiculous. Additionally, the entire discussion in (k) (f) regarding the maximum allowable annual rental represents an element of micro-management by the Department that is completely unnecessary and will significantly add to total costs.

(a) Rental costs for space that is used by the RTF is allowable.

(b) Leasing or rental costs for buildings are allowable if parties are unrelated and the facility demonstrates that the rental or lease is an arm's length transaction and continues as such.

(c) Exceptions to paragraph (2) are allowed if the rental costs are based on a fair market rental appraisal as outlined in paragraph (5), or documented costs of ownership, except that return on equity is not permitted.

Documented mortgage interest charges and depreciation are allowable costs.

(d) AN RTF shall maintain adequate documentation to substantiate rental costs. Documentation shall include copies of the Department's approval specified in paragraph (3), if applicable, the lease, and bills for taxes, insurance, and interest.

(e) AN RTF shall maintain documentation of a fair market rental appraisal for all rental properties, from an individual who is a member of the Appraisal Institute, which includes the documented market value of three similar properties including land in the same geographic area.

(f) The maximum allowable annual rental shall be computed as follows:

(i) The property value is based upon the documented fair market value as determined in subsection(k)(5).

(ii) Net equity is obtained by reducing the property value by the estimated selling costs and any outstanding debt.

(iii) Net equity will be multiplied by the rate for return on equity capital as published by CMS in the "Average Trust Fund Interest Rates", and announced in an annual bulletin published by the Department, for the beginning of the current fiscal year.

(iv) The actual cost of real estate taxes, insurance and interest on any debt, for the current fiscal year, are added to the amount in subsection (iii).

(v) The maximum annual rental may not exceed the sum of paragraphs (iii) and (iv).

(g) AN RTF shall maintain documentation of the calculation required in paragraph (6).

(h) Rent is allowable up to the maximum allowable annual rental value.

(i) If an RTF has a multiple-year lease, allowable rental costs are determined by new appraisals or by updating the existing appraisals using the interest rate as published by CMS in the "Average Trust Fund Interest Rates", and announced in an annual bulletin published by the Department, and including current costs for taxes, insurance, and interest as specified in paragraph (6)(iv).

(j) A new appraisal must be issued for every new lease or lease renewal in order to determine the allowable rental costs.

Comment:

The requirement to have appraisals for all leased property including, in the case of multi-year leases, annual updates to those appraisals will increase costs significantly and unnecessarily.

(l) Vehicle costs.

(1) Leasing or rental costs of automobiles are allowable if the RTF can demonstrate

that the transaction is an arm's length transaction.

(2) Leasing or rental costs of automobiles are allowable if the automobile is leased or rented from a parent corporation if the RTF can demonstrate it is

leasing or renting at less than or equal to the amount other vendors are charging for a similar automobile.

(3) An RTF shall use a competitive bidding process in order to purchase or lease vehicles.

(4) An RTF shall explore cost differentials between leasing and purchasing of vehicles and shall choose the least expensive alternative in order to be allowable.

Comment:

(l)(d) This provision should be deleted. Selecting the least expensive alternative in every lease vs. buy decision often will make no sense due to other factors such as service, flexibility, reasonable useful life of an asset, financing abilities, etc.

(5) The expenses related to the personal use of RTF-owned or leased motor vehicles by staff, owners or officers are not allowable.

(6) Daily logs detailing use of vehicles as well as the maintenance activities and costs shall be maintained by the RTF.

(m) Purchases. Purchase of services, major renovations, capital equipment, and supplies that exceed $5,000 annually are allowable if they are made through a competitive bidding process or a request for proposal process.

Comment:

(l)(m) $5,000 is way too low a threshold for requiring a competitive bid process and represents another form of unnecessary micro-management by the Department.

(1) Professional services including those of health care practitioners and attorneys

are exempt from this requirement.

(2) A bid may be obtained for a maximum of 3 years.

(3) An RTF shall not purchase in a piecemeal fashion to avoid the $5,000 limit.

(4) Purchases without bids shall be based upon sole source justification supported by documentation of the uniqueness or the limited availability of the service.

(n) Transportation.

1. Transportation expenses are allowable for travel, lodging, subsistence and related items incurred by staff traveling on official business. Reimbursement for transportation expenses shall not exceed that paid to employees of the Commonwealth.

Comment:

(n)(a) Please offer additional detail as to what is meant by "Reimbursement for transportation expenses shall not exceed that paid to employees of the Commonwealth." How is this a reasonable comparison? Do Commonwealth employees have access to state-owned vehicles? Generally speaking, mileage reimbursement should be limited to the prevailing IRS rate.

2. Costs incurred in transporting the parent and, when applicable, he guardian or custodian to a family therapy appointment at the facility where the child is present are allowable.

(o) Start-up costs.

(1)Start-up costs are costs that incurred prior to the first day of officially operating as an RTF. Start-up costs are allowable and shall be capitalized as deferred charges and amortized over a minimum of 5 years.

(2)Start-up costs include the following:

(i) Administrative salaries.

(ii) Utility costs.

(iii) Taxes.

(iv) Insurance.

(v) Mortgage and other interest.

(vi) Staff training costs.

(vii) Repairs and maintenance.

(viii) Housekeeping.

(ix) Other allowable costs incurred prior to the first day of officially operating as an RTF.

(3)Costs that are properly identifiable as organization costs or capitalizable as construction costs shall be classified as such and excluded from start-up costs.

(4)Costs related to changes in ownership as defined in § 23.301(i)(11) are not allowable as start-up costs.

(5)Amortized start-up costs shall be reported in General Administration on the budgeted cost report or the cost report. The costs shall be documented on the budget narrative or the cost report. A 60-month amortization period is allowed for these costs.

§ 23.302 Income and offsets to allowable costs.

(a) In the cost report, the RTF should report Income from the following as sources to offsets allowable costs in the determination of operating costs:

(1) Payment made by a child or assessed liability that is deducted from the amount billed for the child.

(2) Gifts, donations, endowments, bequests and contributions restricted by the donor for allowable costs.

(3) Refunds and cash discounts.

(4) Grants designated for allowable costs.

(5) Income from the National School Lunch Program.

(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.

(7) Income from space rental, vending machines and similar items.

(8) Fund-raising efforts restricted for allowable costs

Comment:

Regarding (a) (8), offsetting the results of fund raising efforts implies that the cost of the efforts themselves is allowable. Is that the case?

(8) Interest earned on items specified in paragraphs (1)—(8).

§ 23.303 Bed Occupancy.

(a) Minimum occupancy rate.

(1) In calculating an RTF's per diem rate, the Department will compute the number of RTF days of care used at 85% of available days of care if a provider reports an occupancy percentage of less than 85%.

(b) The average annual rate of occupancy is computed by dividing the total actual days of care provided by the total certified bed days available during the fiscal

period. The total actual days of care provided include all days of service actually provided plus hospital reserve bed days in full up to the limits specified by § 23.307(b)(1) (relating to general payment policy). Reserved beds counted as actual days of service shall not be filled.

Comment:

(b) If therapeutic leave days are not going to be considered a "day of care", then any calculations regarding per diem costs must exclude them from the denominator. In other words, total costs should be spread over total allowable days of care, which would exclude TL days. Similarly, if a lower rate is applicable to reserve bed days (i.e., 1/3), those days should only count as a 1/3 of a day of care for this purpose.

§ 23.304 Cost allocation.

(a) Cost allocation method.

(1) If a provider operates an RTF as well as other types of programs, the provider shall document at the time of the independent audit how various costs are allocated between the multiple programs, under §23.301(c) (relating to allowable costs).

(2) The account of the cost allocation shall include the following:

(i) Salary costs for individuals responsible for more than one program.

(ii) Staff fringe benefits for individuals responsible for more than one program.

(iii) Rental costs that apply to more than one program.

(iv) Motor vehicles that are used by more than one program.

(v) Other related expenses shared by more than one program.

(b) Disclosure.

(1) If costs have been allocated between programs and supporting services, disclosure shall be made in the independent audit and in accordance with generally accepted accounting principles in the independent audit.

Comment:

(b)(a) This provision should be deleted. There is no reference to allocation methodologies in GAAP and, therefore, it should not be included in the independent audit. Auditors would have a very difficult time expressing an opinion on the allocation methods of the RTF.

(2)An RTF must disclose in the independent audit the existence of any affiliate and its relationship to the established RTF, including the nature of any financial transaction between the affiliate and the RTF.

(c)Cost Centers. An RTF that operates RTFs in different locations, but uses a consolidated financial report shall designate cost centers for each location in the independent audit. Information accompanying the independent audit shall include the basis used to allocate income and expenses to each location.

§ 23.305 Related-party transactions.

(a) AN RTF may include in its allowable costs, services and supplies furnished to the RTF by a related-party at an amount equal to the cost of such services and supplies to the related-party.

(b) The cost of services and supplies procured by the RTF through a related-party transaction may not exceed the cost of comparable services and supplies if purchased elsewhere.

(c) The related party's costs include reasonable costs incurred in the furnishing of services and supplies to the provider.

§ 23.306 Costs, limitations and services excluded from the RTF per diem rate.

(a) The following costs are excluded from the operating costs as described in §23.301 (a) (relating to allowable costs) and not included in the RTF per diem rate:

(a) Costs for legal services relating to litigation against the Commonwealth, including administrative appeals, if the litigation is ultimately decided in favor of the Commonwealth of Pennsylvania.

(b) Administrative costs in excess of 13% of allowable medical assistance costs as specified in § 23.301(c) (relating to allowable costs).

(c) Costs for which Federal Financial Participation is precluded by statute including any services not on the ISP or services on the ISP not provided by and in the facility to residents of the RTF.

(d) Education costs associated with the child's Individual Educational Plan, Individual Family Service Plan, and ISP which are to be paid for by the child's school district.

(e) Costs related to direct medical education, residency programs and education field placements, including staff costs.

(f) Costs for a service if payment is available from another public agency, insurance or health program, or any other source.

Comment:

(a)(f) This section disallows costs for any service for which payment is available from another public entity. If funding for a necessary service is not available, does the department maintain that such cost is allowable? An example could be medical care for clients in residential placement. There are times when a provider, where feasible, coordinates care with a child's primary care physician (PCP) and requests the client to obtain services from the PCP while on home

visits. However, in many cases, this is not practical either due to the client's family situation, status in the program, or geographic limitations. As a result, a provider may utilize staff or contracted physicians to provide these services in such cases. Since many clients are in RTFs for a relatively short period of time, it is not practical to change the PCP (i.e., change who receives the monthly capitation payment) for the period of treatment. So, providers typically absorb the cost of these services. In such cases, these costs should be allowable.

Such costs should be included in RTF reimbursement as the alternative would be for the MA program to pay the costs of transportation and staff accompaniment back to the client's home PCP for all such services. Providers believe this option to be far more expensive for DPW and also more disruptive to the client's treatment program.

(g) Expenses not related to providing services to MA recipients.

(h) The Department will not contribute to a return on equity for proprietary programs.

(i) Costs associated with the following:

(i) Advertising (excluding employment opportunities).

Comment:

(a)(i)(i) This section disallows non-employment advertising. However, if an RTF is being held to a minimum occupancy level of 85% (Sec 23.312(a)(2)), then what recourse does it have to market its program and attempt to fill beds? Thus, these costs should be allowable.

(ii) Charitable contributions.

(iii) Staff recognition, such as gifts, awards, dinners.

Comment:

(a)(i)(iii) Staff recognition, up to some reasonable limit, should be allowable. This is part of the overall staff retention effort and is typically far less costly than recruitment costs associated with staff turnover. Excluding them is short-sighted.

(iv) Staff social functions, such as picnics, athletic teams.

(iv) Non-standard fringe benefits

Comment:

(a)(i)(v) What are non-standard fringe benefits? The Department should clarify.

(vi) Fund raising and marketing

(vii) Life insurance for officers and directors of the governing board, including life insurance premiums necessary to obtain mortgages and other loans.

(viii) Membership fees for social, fraternal, and other organizations involved in activities unrelated to the program or an organization defined as a lobbying group under the Lobbying Registration and Regulation Act (46 P. S. §§ 148.1—148.9).

(ix) Meals for visitors.

(x) Political activities.

(xi) Related-party rental, leases or other payments in excess of the provision outlined in § 23.305 (relating to related-party transactions).

(xii) Reorganization costs.

(xiii) Federal, state or local income and excess profit taxes.

(xiv) Taxes from which exemptions are available to the provider.

(xv) Bad debts and contractual adjustments.

(xvi) Barber and beautician services.

(xvii) Client allowances.

(xviii) Clothing and shoes for children placed in the RTF.

(xix) Living expenses for live-in employees, including lodging, meals and personal laundry.

(xx) Meals for employees, except for employee meals provided as part of client training activities document in the child's treatment plan.

Comment:

(a)(i)(xx) The qualification should be broader than client training activities. The provision of meals to staff with direct client supervision is necessary for good continuity of care and more efficient than granting staff breaks requiring others to fill in.

(xxi) Penalties, fines or late charges assessed by any source, whether or not related to the RTF.

(xxii) Personal hygiene items for children placed in the RTF.

(xxiii) Personal travel for employees, including personal use of an RTF vehicle.

(xxiv) Transportation and living costs associated with on-site family visits.

(xxv) Nonworking officer salaries

(xxvi) Free care or discounted services.

(xvii) Personal telephone service.

(xxix) Personal radio and television service.

(xxx) Direct and indirect costs related to non-allowable cost centers as follows:

(A) Gift, flower and coffee shops.

(B) Homes for administrators or pastors.

(C) Convent areas.

(D) Nurses' quarters.

Comment:

(a)(i)(xxx)(D) What is meant by "nurses' quarters"? Why is this a non-allowable cost center?

(xxxi) Pennsylvania Capital Stock and Franchise Tax.

(xxxii) Collection expenses associated with bad debts.

(xxxiii) Travel expenses for members of the governing body unrelated to the program.

(xxxiv) Vocational rehabilitation services.

(xxxv) Parties and social activities not related to providing care to MA recipients.

(xxxvi) Recreation costs not related to providing care to MA recipients.

(xxxvii) Charity, in-kind and courtesy allowances.

(xxxviii) Extraordinary costs related to, or precipitated by, bankruptcy.

(j) The following services are not included in the per diem and may not be included as a facility cost and will not be reimbursed by Medicaid for any residents of the RTF:

(i) Health care, which is not related to behavioral health.

(ii) Prescription drugs.

(iii) Ambulance services.

(iv) Methadone maintenance.

(v) Diagnostic procedures or laboratory tests.

(vi) Dental services.

(vii) Inpatient hospitalization.

(viii) Emergency room visits.

(ix) Diagnostic or therapeutic procedures for experimental, research, or educational purposes.

(x) Experimental or investigation procedures or clinical trial research and services that are not in accordance with customary standards of medical practice or are not commonly used.

(b) Limitations on reimbursement.

(1) Costs that are not recognized as allowable costs in a fiscal year shall not be carried forward or backward to other fiscal years for inclusion in allowable costs.

(2) Costs of services otherwise included in the ISP that are provided by and in the RTF may be billed by the RTF's subcontractors. However, if the service is not listed on the ISP or is not provided by and in the RTF, Medicaid reimbursement to a subcontractor of the RTF or independent provider is not permitted, including the following:

(i) Health care, which is not related to behavioral health.

(ii) Prescription drugs.

(iii) Methadone maintenance.

(iv) Diagnostic procedures or laboratory tests.

(v) Dental services.

§ 23.307. General payment policy.

(a) General payment policies.

An admission to an RTF is subject to a retrospective review by the Department in addition to prior authorization review. If the medical record does not support the medical necessity of the admission or continued stay, or if care rendered is found to be inadequate, inappropriate, or harmful to a child, payment may be denied for all or part of the stay. Suspected cases of fraudulent practices by the RTF may be referred for further investigation to the Office of the Attorney General, Medicaid Fraud Control Unit or other agencies, as appropriate.

(b) Limitations on payment.

(a) Payment for hospital-reserved bed days:

(i) Payment to an RTF to reserve a bed when a child is hospitalized will only be made if the child is admitted to a licensed hospital or hospital unit accredited by the

JCAHO as a hospital, the hospitalization occurs during an RTF stay, and the child is expected to return to the RTF.

(ii) Payment for hospital-reserved bed days is limited to 15 days per calendar year, per child, whether the child was in continuous or intermittent treatment at one or more RTFs during the calendar year. If a child does not return to the RTF, the child shall be deemed discharged on the date of admission to the hospital and hospital-reserved bed days will not be paid for.

(iii) Payment for hospital reserved bed days will begin on the date of the child's admission to the hospital and will be paid at the rate of one-third of the RTF's approved per diem payment rate.

(b) Payment for absence without authorization.

The Department will make payment for up to 2 days of absence without authorization from an RTF when the conditions specified at §23.282(c) (relating to policy) are met.

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

(a) A day of care solely for the purpose of performing evaluations, diagnostic tests or tests not related to a diagnosis that requires behavioral health services in an RTF.

(b) A day of care during which the child was absent from the facility:

(i) Absence without authorization, unless the absence meets the criteria at subsection (b)(2).

(ii) Elopement.

(iii) Discharge against medical advice.

(iv) Hospitalization, unless the hospitalization meets the criteria at subsection (b)(1).

(v) Therapeutic leave.

(vi) Administrative leave of any kind.

(c) Custodial-care related or unrelated to court commitments. Payment for services provided to a child in an RTF under a court commitment will be made only if the RTF services are medically necessary and the child was not placed in the facility by the court system.

(d) Unnecessary admissions and days of care due to conditions which do not require services in an RTF.

(e) A day of care for a child who no longer requires services in an RTF.

(f) A day of care for a child who does not have a current DSM diagnosis including Axes I-V or ICD-9-CM diagnosis along with Axes III-V of the most current DSM supported by clinical documentation.

(g) A day of care not certified in accordance with the Department's admission and continued stay review process described at §§23.315 and 23.316 (relating to admission certification and continued stay certification request).

(h) A day of care caused by a delay in requesting or performing necessary diagnostic studies or consultations.

(i) A day of care on or after the effective date of a court-commitment to another RTF.

(j) A day of care due to a delay in applying for a court-ordered commitment.

(k) A day of care provided to a child who is suitable for an alternate non-residential treatment type or level of care, regardless of whether the child is under voluntary or involuntary commitment.

Comment:

(c)(k) In this provision, it is indicated that DPW will not pay for a day of care for a child who is suitable for an alternate non-residential treatment type of care. Generally speaking, this makes sense but what if the BH-MCO or other placing agency has no such place for the child to go? They may no longer be suitable but they are basically requiring the RTF to continue service. Shouldn't there be some qualification for this situation?

(l) The day of discharge or transfer to another facility.

(m) A day of care disallowed by the inspection of care requirements specified at § 23.331 (relating to inspection of care reviews: general).

(n) A day of care where the ISP was not in place under §§ 23.223 and 23.224 (relating to development of the ISP and content of the ISP).

(d) If a determination is made, by an audit or other determination, that the RTF received excess funds in the form of an overpayment from the Department, the funds shall be returned to the Department within 6 months from the date the facility is notified.

§ 23.308. Third-party liability.

(a) RTFs shall utilize available third-party resources, including Medicare, Part B for services a child receives while in the RTF.

(b) If expected payment by a third-party resource is not received, an RTF may bill the Department for days of care authorized by the Department and provided to the child.

(c) If an RTF receives reimbursement from a third-party subsequent to payment from the Department, the RTF shall repay the Department by submitting a replacement of prior claim, according to instructions in the Department's Provider Handbook and Billing Guide.

(d) If a child or the legal representative of a child requests a copy of the record of payment or amounts due, an RTF shall submit a copy of the invoice and the request to the Department's Office of Administration, at the address specified in the Department's Provider Handbook and Billing Guide.

(e) Except as specified in subsection (f), if a child has private insurance benefits, the Department will pay the lesser of the following:

(a) AN RTF's per diem payment rate multiplied by the number of covered days, minus any third party resources available to the child for the care, including any Medicare Part B payment.

(b) The amount of the insurance plan's deductible and coinsurance minus any other third party resource available to the child for care, including any Medicare Part B payment.

(f) If the third party resources available to a child for care equal or exceed the RTF's per diem rate multiplied by the number of compensable days, the Department will not make payment.

§ 23.309. Payment for services in an out-of-state RTF.

(a) The Department will pay for services furnished by an out-of-state RTF enrolled to participate in the MA program only if the facility meets state requirements and one of the following applies:

(a) The RTF is in a state contiguous to Pennsylvania and located closer to the child's residence than an in-state RTF.

(b) The out-of-state RTF provides a specific program that is medically necessary for a child and is not available in the Commonwealth, as documented in the request for authorization.

(c) AN RTF bed is not available in the Commonwealth after referrals to at least 3 in-state RTFs and all 3 were unable to accept the child.

(b) The per diem rate for services provided by an out-of-state RTF as established at §23.312 (relating to general rate-setting policy) will not exceed the lesser of the following:

(a) AN RTF's home-state Medicaid per diem payment rate for equivalent services.

(b) The average bed-weighted prospective per diem payment rate for RTFs located in Commonwealth adjusted, if appropriate, for specialized care not available within the Commonwealth.

Comment:

(b)(b) How can this standard be used? If a child can only go to an out-of-state RTF because comparable services are not available in state, then how can the baseline be the "bed-weighted prospective per diem rate" for in-state RTFs? In all likelihood, there are a number of factors contributing to the "specialized care" that make such comparisons impossible. Thus, in-state rates should be dismissed from the calculation entirely.

(c) The Department will pay the per diem rate established in accordance with this section minus any payments from the child, a legally responsible relative or a third-party resource.

§ 23.310. Billing requirements.

(a) AN RTF shall submit invoices to the Department pursuant to the instructions in the Department's Provider Handbook and Billing Guide and subsequent instructions issued by the Department.

(b) Original and resubmitted claims, including replacement claims, must be received for final adjudication within 365 days following the last date of service on the invoice.

(c) If the service spans 2 fiscal years, a separate invoice must be prepared for each fiscal year.

(d) If the service spans 2 different per diem rates, a separate invoice must be prepared for each time period covered by the different rates.

(e) Except as specified in §23.306 (relating to costs, limitations and services excluded from the RTF per diem rate), services and items provided to the child while in the facility are included in the per diem and shall be included in the RTF services bill and shall not be invoiced separately.

§ 23.311. Annual cost reporting.

Comment:

This whole section needs to be clarified and adjusted based on consultation with independent auditors who can provide the Department with accurate guidance on what financial information they can reasonably express an opinion. Specifically, the inclusion of a schedule prescribed by the Department as part of the audit can mean many different things. If the Department thinks the auditor is going to express an opinion to this level of detail, then costs will be excessive, particularly for an entity operating multiple programs, in multiple states, etc. We're not convinced they understand what their request entails. Also, would these additional costs be incorporated into the rate?

Additionally, the September 30 deadline is unreasonable. Many agencies do not have an independent audit completed by that time, often due to scheduling issues on the part of the auditors. December 31 would be an appropriate deadline.

(a) **Cost reporting.**

(a) **AN RTF shall provide the Department with an annual cost report and an independent audit performed by an independent public accountant.**

(i) The audit must include a schedule prescribed by the Department containing the financial activity of the RTF(s).

(ii) The cost report shall be prepared on an accrual basis as required in this subchapter and clarified in the Department's cost report instructions.

(b) AN RTF shall identify allowable services, administration, ancillary, and related organization costs based on financial and statistical records maintained by the RTF. The cost information contained in the cost report must be current and accurate.

(c) The cost report must cover a fiscal period of 12 consecutive months, from July 1 to June 30, except as noted in paragraph (5).

(d) The cost report for the preceding fiscal year ending June 30 must be submitted to the Department by September 30 of that year.

(e) When an RTF begins operating after the start of the fiscal year, the cost report must cover the period from the date of approval for participation by the Department to June 30.

(f) If the cost report is not submitted by September 30, the Department will assess a daily penalty of $100.

(b) Review of a cost report.

(a) The Department will utilize the cost report and the annual independent audit to establish the per diem rate applicable to the next fiscal year.

(b) The Department may adjust costs reported in the cost report based upon the findings of current or closed audits, cost settlements, approved service description as defined in §23.221 (relating to

description of services), or as a result of other information the Department requests or is made aware of.

(c) **The Department will inform the RTF in writing of adjustments to the cost report.**

(d) **If the Department does not inform the RTF in writing within 180 days of receiving the cost report of adjustments to the cost report, the cost report submitted by the RTF will be accepted by the Department as submitted.**

(e) **When an RTF files for protection under the bankruptcy laws, a cost report must be filed except where the debtor, RTF, rather than a trustee operates the RTF after the commencement of the bankruptcy. For example, the situation where the debtor, RTF, is the debtor in possession.**

§ 23.312. General rate-setting policy.

Establishment of per diem rate.

(1) The cost report submitted by the provider, as adjusted by the Department, as specified in § 23.311(b) (relating to annual cost reporting), shall be used for the calculation of the per diem rate.

(2) The per diem rate for an RTF will be established by dividing the total projected operating costs by the number of days of care reported in the cost report subject to a minimum of 85% of the maximum number of days based on the number of beds specified on the RTF's Certificate of Compliance.

(3) The total projected operating cost is calculated as follows:

Comment:

3. The terminology "projected operating cost" is used. Not sure what this means. It should really establish a rate, not cost, by taking the operating cost, adjusted for the various factors in (iii), (iii) [duplicate] and (iv), and dividing it by the number of service program days.

(i) For a new RTF, the total MA allowable costs from the budgeted cost report, including adjustments for income and non-allowable, limited and excluded costs, as determined by the Department.

(ii) For an existing RTF, the cost report filed September 30 as specified in §23.311, including adjustments for income and non-allowable, limited and excluded costs, as determined by the Department.

(iii) An adjustment factor for each fiscal year, specified by the Department and announced in a bulletin published by the

Department annually, is used to project the amount in subparagraph (i) or (ii) for each fiscal year through the end of the fiscal year in which the rate is to be effective. The adjustment factor is applied to the total operating costs on the cost report in (i) or (ii) above, less depreciation on capital assets, limited to buildings and fixed equipment, and interest on capital indebtedness.

Comment:

(a)3. (iii) The annual adjustment factor should be based on the Consumer Price Index inflation factor across Pennsylvania, not based on an adjustment factor left to the discretion of the Department. Also, this section references subparagraphs (i) and (ii) which don't appear to exist. But there are two (iii)s.

(iii) Add to the total operating cost depreciation on capital assets, limited to buildings and fixed equipment, and interest on capital indebtedness to obtain the total projected operating cost.

(iv) Add an allowance for retained revenue using a percentage specified by the Department and outlined in a bulletin published by the Department annually.

(4) Once established, the per diem rate shall remain in place throughout the current fiscal year, unless the per diem rate is adjusted as a result of an audit or another determination.

Comment:

(a)4. (iii) Some accounting method changes are mandated by GAAP. The RTF should not be required to submit prior written justification to obtain approval from the Department to change such methods.

(5) 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.

(6) If there is more than one accounting method for handling a cost item, the method initially elected by the RTF shall be followed consistently in subsequent cost reports, unless the RTF submits prior written justification and receives approval from the Department for using a different method.

§ 23.313. Financial records.

(a) AN RTF shall maintain adequate financial and statistical records for determination of costs payable under the MA Program for a period of 5 years after the date of last payment.

Comment:

(a) The Department should clarify what "5 years from the date of last payment" means. Typically, records are maintained for a specified period beyond the date of service, or at least the fiscal year in which the service was provided. Does the last payment refer to a particular client, a billing year, last payment ever made to the RTF, etc.?

(b) AN RTF shall maintain the following records:

(1) General financial ledgers, journals, and books.

(2) Original evidence of cost, such as purchase requisitions, purchase orders, vouchers, vendor invoices, requisitions for supplies, inventories, time cards, payrolls and bases for apportioning costs, that relate to the determination of reasonable costs and that are auditable.

(3) Records related to allocated administrative costs.

(4) Records relating to each cost report.

(5) Cash disbursement journals.

(6) Cash receipts journals.

(7) Payroll journals or computer printouts.

(8) Fixed asset ledgers or equivalent records.

(9) Inventory control records.

(10) Charts of accounts that parallels or cross-walks to the cost report format issued by the Department.

(11) Statement listing all sources of revenue to the RTF, including Federal, State, local, and private sources.

(12) Accounting records.

(13) Documentation of staff compensation, by RTF positions and functionally equivalent Commonwealth positions.

§ 23.314. Evaluations and treatment plans.

(a) After admission, the team members specified at §23.223 (d) and (e) and (f) (relating to development of the ISP) must perform and prepare within the scope of their practice medical, psychiatric and psycho-social evaluations within the following time frames:

(a) Within a maximum of 30 days prior to the Department's receipt of an admission certification request or continued stay request; or

(b) Before authorization for payment, if the child becomes eligible for medical assistance after admission.

(b) Team members specified at § 23.223 (d) and (e) (relating to development of the ISP) shall, within their scope of practice, prepare the treatment plan. The plan shall document the active treatment to be provided and be designed to achieve the child's discharge at the earliest possible time. RTF treatment plans must comply with all requirements at 42 CFR § 441.155(b) (relating to individual plan of care), and 42 CFR § 456.180(b) (relating to Individual written plan of care) based upon face-to-face contact.

(c) A written report of each evaluation, the treatment plan portion of the ISP and update must be entered in the child's record. RTF reports must be

completed at the time of admission or if the individual is already in the facility, immediately upon completion of the evaluation or plan.

§ 23.315. Information required to request admission or continued stay.

(a) Certification of need for RTF services must be included in the documentation specified in subsection (e) and certified by:

(a) The interagency service planning team, prior to admission.

(b) The child's treatment team in concert with the interagency service planning team for continued stay.

(b) For an individual who is an MA recipient when admitted to a facility or program, the interagency service planning team must be independent of the RTF and:

(a) Include a physician.

(b) Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry.

(c) Have knowledge of the individual's situation.

(c) For an individual who applies for Medicaid while in the RTF, such as delayed coverage, the certification must be:

(a) Made by the team responsible for the ISP as specified in 23.223(d), (e) and (f) (relating to development of the ISP).

(b) Cover any period before application for which claims are made.

(d) The Interagency Service Planning team must certify the following:

(a) Ambulatory care resources available in the community do not meet the treatment needs of the child.

(b) Proper treatment of the child's psychiatric condition requires services on an inpatient basis under the direction of a physician

(c) The service can reasonably be expected to improve the child's condition or prevent further regression so that the services will no longer be needed.

(e) Documentation prepared by the ISPT specified in subsection (a) to request admission certification or by the RTF utilization review committee to request continued stay certification in accord with the Department's Utilization Review Manual must include all of the following.

(a) The Department-designated form signed by the prescribing physician or designee

(b) The most recent psychiatric evaluation signed by the treating psychiatrist. The evaluation must be performed no more than 30 days before the planned admission date or the date the request was received by the Department. The child must have a face-to-face psychiatric evaluation that supports a DSM diagnosis, Axis I through V or an ICD-9-CM diagnosis along with Axis III through V of the most current DSM.

(c) The child's current or proposed treatment plan which meets the requirements of § 23.314 (relating to evaluations and treatment plans).

(d) The child's current or proposed plan of care summary.

(e) The completed Department form which describes services considered and tried prior to the recommendation for RTF services and indicates whether the County MH/MR Office recommends admission or continued stay in the facility.

§ 23.316. Admission authorization and continued stay authorization request.

(a) Admissions to and continued stays in an RTF must be prior authorized by the Department or its designee.

(b) A request for prior authorization must be made in accordance with the process specified in the Department Utilization Review Manual and contain the information required in § 23.315 (relating to information required to request admission or continued stay.)

(1) Except as specified in paragraph (2), an admission to an RTF must occur within 30 days of the date the Department approves the admission. If the admission does not occur, a new authorization request must be completed to update the status of the child and certify that RTF care is still medically necessary.

(2) Immediate child-safety or protection admission.

The certification request for a child receiving service through the CCYA or under the jurisdiction of the juvenile court is the same as paragraph (a)(1), unless the child needs immediate admission to an RTF for treatment of behavioral health needs and has associated child-safety or protection needs as determined by CCYA or the juvenile court. For immediate admissions all of the following criteria shall be met:

(A) The child has a DSM-IV (or subsequent version) diagnosis, Axes I through V or ICD-9-CM (or subsequent version) diagnosis, along with Axes III through V, and is not in a mental health or substance abuse crisis.

(B) The child requires admission because of child-safety or protection issues.

(C) The interagency service planning team recommends RTF admission to meet the child's treatment needs.

(D) If the child is admitted to an RTF in accordance with this paragraph, all information to support the admission required in 23.316 must be received by the Department within 14 days of the child's admission.

(E) If the Department denies the admission certification, the Department will not make payment for RTF services for the child.

(c) Recertification for continued stay.

(a) The request for continuation of stay must be made 30 days prior to the expiration of the certified length of stay.

(b) Either of the following conditions apply to request for delayed coverage:

(i) The request must be made within 30 days of the date the child was determined eligible for MA.

(ii) The request must be made within 30 days of the notification by a third-party resource, originally expected to cover the child's treatment, that the requested service is not covered or coverage is exhausted.

(c) Exception. This process does not apply to a period of service which was not covered by another payor because the service was not medically

necessary using the other payor's criteria, or the other entity's payment policies were not followed and, therefore, resulted in a rejection.

§23.317. Authorization determination.

(a) The documentation and information submitted for the authorization request submitted to the Department must include accurate and detailed medical information to establish medical necessity for the admission or continued stay.

(b) The authorization request must include all information specified in §23.314 (relating to evaluations and treatment plans). If the required information is not present, the request will be returned to the county case manager.

(c) The Department will determine whether the requested RTF services are medically necessary, and compensable so that the recipient receives written notice within 21 days of the date the Department received the request. The requested services will be deemed approved if a determination is not made within 21 days.

(d) Department approval is for medical necessity of care and does not assure the child is, will be, or will continue to be eligible for medical assistance services on the date service is provided.

§ 23.318. Effective date of coverage.

(a) Admissions.

(1) Except as specified in paragraph (2):

(i) AN RTF will receive payment beginning on the date of admission if the admission occurs within 30 days of the date the Department authorizes the admission.

(ii) AN RTF shall inform the Department of the date the child was admitted to the RTF.

(2) Immediate child-safety or protection admission.

(i) If the child is admitted under §23.316 (b)(2) (admission authorization and continued stay authorization request) and approvable information is submitted to the Department within 14 days of admission to the facility, the certified days are effective on the date of admission.

(ii) If the child was admitted under 23.316 (b)(2) but the documentation is not received by the Department within 14 days of admission to the facility, the effective date of the approval will be the date complete and approvable information is received by the Department.

(b) Continued stay.

(1) Recertification for a continued stay.

(i) If an approvable recertification request is received by the Department 30 days prior to the expiration of the certified length of stay, the effective date is the first day after the last day previously certified stay.

(ii) If the recertification request is received by the Department less than 30 days prior to the expiration of the certified length of stay, and the stay is approved after the expiration of the previously approved stay, each day of delay in requesting an extension subsequent to the last previously certified

stay shall result in the reduction of a corresponding number of days approved.

(2) Delayed coverage.

(i) If admission procedures were consistent with the requirements in §23.316 (relating to admission authorization and continued stay authorization request) and the child was not determined eligible for medical assistance subsequent to admission, the effective date of the approval will be the date the continued stay certification was requested and approved if the request is made after eligibility was determined, or the date the child is determined eligible for medical assistance coverage if the request was initiated before eligibility was determined.

(ii) If other insurance was expected to pay in full for the service but failed to materialize, the effective date will be the later of the following:

(A) The admission date.

(B) The date the child became eligible for services after the admission.

(iii)If other insurance was expected to pay in full for the service but coverage was exhausted; the effective date will be the later of:

(A) The date coverage was exhausted.

(B) The date the request for certification was received by the Department.

(C) The date the child became eligible for services after the admission.

§ 23.319. Department delegation of responsibility to behavioral health managed care organizations.

Consistent with §23.282(c) (relating to policy) the Department may delegate specific responsibilities to the behavioral health managed care organizations including, but not limited to, rate setting, medical necessity review, so long as the certifications in 23.315(c) (relating to information required to request admission or continued stay) are performed by an independent team meeting the requirements, and the establishment of operational procedures.

Comment:

DPW delegation of responsibility to behavioral health managed care organizations - if this can be interpreted that the BH-MCO's will negotiate rates as OMAP did, which providers were truly able to negotiate prior to HealthChoices, this could address providers concerns raised earlier.

UTILIZATION CONTROL

§23.321. Scope of claim review process.

RTF services provided to a child are subject to the utilization review procedures set forth in this chapter and Chapter 1101 (relating to the general provisions).

§23.322. RTF utilization review.

(a) AN RTF shall have an RTF utilization review plan.

(b) AN RTF shall have a utilization review committee composed of two or more physicians, one of whom is knowledgeable in the diagnosis and treatment of mental diseases, and assisted by other professional personnel.

(c) AN RTF utilization review committee may not include an individual who is directly responsible for the care of a child whose care is being reviewed or has a financial interest in the RTF.

(d) AN RTF utilization review committee shall:

(1) Conduct reviews of a child's need for admission to an RTF and continued need for residential treatment services.

(2) Ensure that complete documentation is obtained.

(3) Ensure that reauthorization request for continued stay is submitted to the Department with the appropriate time frames specified at §23.315 (relating to admission certification and continued stay certification request).

(e) AN RTF shall maintain the original signed copy and continued stay copies of the request documentation and the notification of the number of days certified with the child's medical records. Another copy of the notification of days certified shall be maintained with the RTF billing records.

(f) AN RTF's utilization review committee representative shall notify the Department, according to the schedule established by the Department of the following:

(1) A child's admission to the RTF.

(2) A child's discharge from the RTF.

(3) Denial of admission or continued stay.

(g) AN RTF shall maintain utilization review records for a minimum of 6 years from the date of submission of that year's end cost report or until any audit or litigation is completed, whichever is later.

(h) The RTF shall submit all clinical and fiscal records and other documents to the Department upon request within the timeframe specified by the Department in the request.

Comments:

In the section related to utilization control there is a requirement that providers " (3) have in effect a utilization review plan that meets the requirements set forth at CFR 42 part 456 subpart D (relating to utilization control: metal hospitals.....) It says in that regulation that the psychiatrist should have no interest in the organization providing the service. Does this mean that the psychiatrist has to be hired/engaged but not be on staff of the facility? Can they be a psychiatrist who provides treatment services to other children in the program?

Some providers engage a psychiatrist who is an Independent contractor to chair the utilization review committee. This creates a truly independent relationship has this psychiatrist does not provide any clinical services to children. This is an expensive and cumbersome way to meet this requirement.

Many RTFs use their own psychiatrists to staff this committee and try to have psychiatrists who are not providing services review the "other" children. Can a psychiatrist who is currently engaged in providing clinical services can provide utilization review of the work/treatment to other children in the RTF?

§23.223. Adverse determinations.

When the RTF utilization review committee denies admission or continued stay, an adverse determination letter must be sent to the county MH/MR office, the Department, the behavioral health MCO, the CCYA with custody of the child, if applicable, and the JPO, if applicable.

INSPECTION OF CARE REVIEWS

§23.331. Inspection of care reviews: general.

(a) The Department will conduct an unannounced onsite visit as deemed appropriate by the Department to determine if the RTF continues to meet State and Federal regulations.

(b) AN RTF shall provide the Department with a list of MA recipients in the RTF on the date of the visit.

(c) AN RTF shall make the medical records of an MA recipient available to the Department representatives reviewing the RTF.

(d) AN RTF shall ensure that MA recipients are available to meet in person with the Department representatives reviewing the RTF.

(e) The Department will determine through its review whether State and Federal regulations are met.

§23.332. Inspection of care reports.

(a) The Department or designated agent will report the outcome of the inspection of care review to an RTF.

(b) If the individual or team reviewing the RTF recommends alternate care for a child:

(1) The Department or a designated agent will notify the child or the child's representative and the RTF Director of the intended denial of payment authorization.

(2) The child or the child's representative has 30 days from the date the notice is mailed to grieve the decision or request a fair hearing. The RTF does not have the right to grieve or request a fair hearing unless it is acting as a child's representative.

(3) If the child or the child's representative requests a fair hearing within 10 days from the date the notice is mailed, payment for RTF care will continue pending the outcome of the hearing.

(4) If a fair hearing is requested more than 10 days from the date the notice is mailed, payment for RTF care is discontinued effective with the day the individual or team reviewing the RTF recommended alternative care.

(c) If the report from the individual or team reviewing the RTF cites deficiencies, the following apply:

(1) AN RTF shall submit a written response to the identified Department office within 30 days of the control date shown on the summary report. The Response shall outline the RTF's planned course of action including the timeframes for correcting deficiencies.

(2) The individual or team reviewing the RTF will conduct follow-up visits to determine if the deficiencies have been corrected.

ADMINISTRATIVE SANCTIONS

§23.341. Provider abuse.

(a) If the Department determines that an RTF has billed for services inconsistent with this chapter, provided services outside the scope of customary standards of medical practice, or otherwise violated the standards set forth in the provider agreement, the RTF shall be subject to the sanctions in Chapter 1101 (relating to general provisions) up to and including termination from the MA program.

(b) If the Department determines that services or items provided by the RTF were not provided according to standards of practice for the particular discipline providing the service or were not medically necessary or were inappropriate, or otherwise non-compensable, the Department will deny payment for the services

and items and related services and items and recover payment already made for the services and items and related services and items.

§23.342. Administrative sanctions.

If the RTF utilization review committee fails to conduct a continued stay review or fails to notify the Department within 30 days of the expiration of the previously assigned length of stay, the Department will not certify those days between the expiration of the previously assigned length of stay and the date the request for continued stay is received.

PROVIDER RIGHT OF APPEAL

§23.351. Provider right of appeal.

(a) AN RTF may appeal adverse actions, including authorization, certification and payment, of the Department under 55 Pa.Code Chapter 41 (related to Medical Assistance provider appeal procedures).

(b) RTF staff and subcontractors shall not have the right to appeal under this chapter or Chapter 41.

(c) If an RTF appeals a decision by the Department to fully or partially deny payment for a child, the Department will withhold the denied payments pending a decision on the appeal. If a child is in an RTF and receiving services from an RTF, payment will continue.

(d) A child, parent and, when applicable, guardian or custodian, may appeal a denial of authorization, or the provider may appeal on behalf of the child as specified in 55 Pa.Code Chapter 275 (relating to appeal and fair hearings and administrative disqualification hearings).

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CHAPTER 3800. CHILD RESIDENTIAL AND DAY TREATMENT FACILITIES

GENERAL PROVISIONS

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§3800.3. Exemptions.

This chapter does not apply to the following:

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(8) Community residences [for individuals with mental illness that provide care to both children and adults in the same facility or community residential host homes for individuals with mental illness that are] certified under Chapter 5310 (relating to community residential rehabilitation services for the mentally ill).

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(12) Residential treatment facilities licensed under Chapter 23 (relating to residential treatment facilities).

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CHAPTER 5310. COMMUNITY RESIDENTIAL REHABILITATION

SERVICES FOR THE MENTALLY ILL

Subchapter A. GENERAL PROVISIONS.

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§ 5310.3. Applicability.

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(b) This chapter [does not apply] applies to child residential facilities which serve exclusively children [which are governed by Chapter 3800 (relating to child residential and day treatment facilities)].

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Miscellaneous Comment:

While DPW has the right to review provider policies, it is not clear that they should be given the right to approve or disapprove policies. The provider is the one that will be held legally accountable for the policies. Unless the Department wants to indemnify the provider for the content of the policies, it would seem that DPW's role should be limited to requiring that policies are consistent with regulation – but not to approve the policies themselves. More importantly, by allowing DPW to approve specific policies, it would seem to create an avenue with which to potentially bypass the regulatory review process. Suppose, for example, that a DPW official decided to approve behavior modification policies that forbade the use of restraint under any condition. The regulations permits emergency use of restraint, but by allowing DPW to approve/disapprove policies, the regulation could be circumvented.

The recommended record retention period is not consistent with litigation standards. For children, records should probably be retained several years past the 21st birthday, regardless of when they left treatment. It would probably be appropriate to consult with an attorney regarding the correct time frame for retention.

Providers support improved quality across the entire continuum of services available to consumers, not just specific to RTFs. It is hoped that as more children are denied access to RTFs, the community-based services are prepared to meet the significant needs of these families. As it stands today, RTF providers experience difficulty in discharge planning due to a lack of available services in the community. One could expect this problem to worsen as more and more RTFs close their doors.

Therapeutic Bed Days Not Allowable
It is estimated by One provider that they will have to absorb $95,000 for not being compensated for the 48 Therapeutic Leave Days currently allowed. This item being considered an unallowable item is contradictory to the concept of integrating the client back into the community setting and/or home. The therapeutic leave days are a vital component to the successful transition of the client. The RTF still incurs operating costs related to the RTF programming (staffing costs, occupancy costs etc.), in addition to the costs of transportation, regardless of the absence of several clients on any given day. How are providers

supposed to handle this additional cost? New per diem rates will need to factor this component into the formula.

Unallowable Items
There is still a question surrounding who will cover the costs of unallowable items such as personal care products, clothing, allowances, haircuts etc. It is estimated by one provider that they will incur $52,000 worth of these costs needed to provide adequate residential care. When there is no county CYF or JPO involvement, the provider is often left without adequate compensation for these costs since many parents are unable to provide any monetary reimbursement for such items. In addition, when billing CYF for these costs, some counties refuse to pay the monies stating that we cannot bill for them. They claim the provider must accept the BH-MCO's payment as "payment in full" and not request additional funds above the BH-MCO's payment. Can further clarity around why these items are unallowable and/or whether or not providers can bill others for these unallowable items be provided?

It has been a long time in development and necessary that Residential Treatment Facilities in Pennsylvania have specific regulatory standards to operate their programs. The most outstanding concern and number one issue, that if not addressed at the statutory level will continue to force the closing of RTF providers in the Commonwealth, is the concern of rate negotiation. Many RTF providers have not had a rate increase going on 7 years, despite continued escalating operating costs.

It has been stated that the new regulations will be cost neutral and that the expenses associated with the will be approximately 10-15% and will be offset by reduced bed days. One estimate, with the proposed staffing ratios combined with the travel expenses for family work, is that the increases will be anywhere from 30%-40% dependent on the current rate and the site.

If Providers are to assume the lower increase the state predicts, none of this matters if the contracted counties do not permit the BH-MCO's to increase the rate as part of their HealthChoices contract. This is the current reality for providers. Contracts with counties and BH-MCO's all over the Commonwealth reflect that, with the exception of a few counties, most refuse to negotiate a new rate. Providers cannot continue to operate at 2002 rates and expect to provide the high quality of service that counties have been accustomed to without continued closing of programs. This will ultimately have a negative impact on consumer choice for RTFs because there will be very limited choice.