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Kroh, Karen

From: Mochon, Julie
Sent: Thursday, December 22, 2016 10:15 AM
To: Kroh, Karen
Subject: LATE: comment on proposed 6100 regulations
Attachments: FINAL Comments on the Proposed 6100 Regulations.docx

From: Kathy Norton [mailto:KNorton@stjosephscenter.org]
Sent: Thursday, December 22, 2016 10:00 AM
To: Mochon, Julie
Subject: comment on proposed 6100 regulations

My name is Kathleen Norton and I am an employee of Saint Joseph's Center in Scranton. In my position I recruit and work with volunteers and assist with fundraising efforts and public education on the services of the Center. Please read and consider these comments as they will impact the delivery of services that are very important to area individuals who receive the service and to the people who provide the services as well. Thank you for your consideration.
Kathy Norton

KN-

Comments on the Proposed 6100 Regulations

6100.01 – Comment and Suggestion: Subsection (a) omits mention of an essential purpose of chapter 6100 – the adoption of HCBS payment policies. Redraft (a) to reflects the broad purpose of Chapter 6100 and includes a reference to "Everyday Lives: Values in Action".

6100.02 – Comments and Suggestion: The provisions of the federal waivers have not been subject to the regulatory review process including review and approval by the IRRC, the Attorney General and the Legislative Standing Committee. It is essential that the intended mandatory provisions of the federal waivers be reflected in regulation consistent with the requirements of state statute and case law. See: 71P.S.~~745.1et seq., and case law: NW.Youth Services, Inc. v. Department of Public Welfare, 66A. 3d 301(Pa. 2013); Borough of Bedford v. +D.E.P., 972 A. 2d 53 (Pa. Comwlth. 2009)

6100.03 Comments and Suggestions: Add a definition for "Service Implementation Plan" as stated in tag # 6100.226(b) AND Common definitions for the several sets of regulations should be included in 6100.3 and the applicability of Chapter 6100 should be noted in each of the other regulatory chapters to promote clarity and consistency across applicable services and programs.

6100.42 Monitoring Compliance – Change the title of this section to: "Review of Provider Performance". Delete (a) and replace with – "The Department and the Lead Designated Managing Entity may review provider compliance with the provisions this Chapter as set forth in this section. When services are provided across multiple counties or individual services are managed through multiple counties by various Designated Entities, one Designated Managing Entity shall perform a provider performance review.

Delete (b) and replace with "The provider review process may include review of a provider's policies, procedures, and records (including invoices for applicable services) related to provision of services under this Chapter.

Delete © (d) (e) and replace with (c)" A provider shall completed a corrective action plan for non-compliance or alleged non-compliance with this Chapter on a form specified by the Department within 20 days of receipt of a written notice of a deficiency finding".

Delete (f)(g) and replace with (d) "The Department or the designated managing entity, after and in consultation with the provider, may issue a directed corrective action plan to direct the provider to complete a specified course of action to address a finding of regulatory non-compliance. A directed action plan is not considered a routine action and shall be authorized only upon a written justification by the Department or managing entity of the need for the plan. The terms of the plan must demonstrate the need for the particular corrective action(s) and must identify the cost to the provider to implement the plan.

Deleted (h) (1) (2) (3) (4) (5) (6) (i) (j) and replace with (e) "A provider must comply with the corrective action plan or directed corrective action plan as approved by the Department or the designated managing entity.

Delete (k) and replace with (f) " the provider shall maintain documentation relating to its implementation of a corrective action plan or directed corrective action plan.

Comment and Suggestion 6100.42 This entire section should set forth toward the end of the Chapter rather than appear at the outset. The text has been edited to reduce redundancy and to promote clarity and reasonableness.
6100.45 Quality Management – Delete (a) (b) (1 through 9) (c) (d) (e) and replace with "A provider shall adopt and implement an evidenced based, quality improvement strategy that promotes continuous improvement, monitoring, remediation, measurement performance and experience of care. In developing its quality improvement strategy, a provider should take into account the following factors;
(1) the provider's performance data and available reports from the Department's information reporting system.
(2) The results from provider monitoring and SCO monitoring.
(3) The results of licensing and provider monitoring.
(4) Incident management data, including data on incident target(s), repeated or serious incidents, root cause analyses, and quarterly review of incidents.
(5) Result of satisfaction survey and review of grievances.
(b) The provider shall adopt the following tasks as part of its quality improvement strategy:
(1) Goals that measure individual outcomes, experience, and quality of care associated with the receipt of HCBS and related to the implementation of PSP
(2) Target objectives that support each identified goal.
(3) Performance measures the provider shall use to evaluate progress.
(4) Identity of the person(s) responsible for the quality improvement strategy and structure that support this implementation.
(5) Actions to be taken to meet the target objectives.
(e) A provider must review progress on the quality improvement strategy and update at least every 2 years.
(f) A provider shall maintain a written copy of the quality improvement strategy to be available for the Department to review as part of provider monitoring.
(g) This section does not apply to an SSW provider and to a provider of HCBS in the Adult Autism Waiver."

Mandating performance data review in all 9 areas as listed put a burden on this provider. This mandate will cost this agency $27,000.00 for a part time staff position as we do not currently have the manpower to monitor quarterly and evaluate the data in all areas listed.

Comment and suggestion – The proposed replacement items of this section reflects statewide provider experience with licensing review, HCBS monitoring and industry best practice.

6100.46 Protective Services – Comments and Suggestions (b) It is suggested that this section take in to account other outcomes of an investigation such as inconclusive or unconfirmed. It should be considered that current expectations within the licensing regulations identify that an alleged or suspected target being investigated for potential abuse may either be separated from working with individuals or supervised at all times when working with individuals.

6100.52 Rights Team – Comments and Suggestions – this entire section should be deleted as there is a process in place.

This section merely adds an unnecessary bureaucratic layer to providers and families. The concept of evaluating the potential and actual violation of rights is essential and, in fact is already appropriately covered in the Incident Management process which includes a thorough investigation by an investigator who has been certified in the Department-approved training. As part of the well-established Incident Management system, all allegations of rights violations must be investigated. As proposed in item (1) to have the Rights Team review each incident is excessive and has the potential to interfere with the CI investigative process. As part of the Department approved training – all investigations are to be confidential so as to protect the reporter and the alleged target (should he/she be innocent). If a violation of rights is confirmed, there is an existing process has established corrective action follow-up.

Additionally, the reported incident and the investigation has further review by the person responsible for Incident Management within the agency, the provider CEO, the responsible AE and then finally ODP, not sure the benefit of having a Rights Team review!!!

Items (c) and (f) are contradictory – (c) states that members of the team shall include the affected individual and family but (f) states that the team shall meet at least once every 3 months. If the Rights team is to include the individual and family when an incident occurs, what Team is meeting every 3 months?? Why and who is on this Team that is meeting???

6100.54 Recordkeeping – Redraft to "Maintenance of records" – Comments and suggestions – The list of who has access to an individual's records does not meet the current Provider Monitoring requirements. Add to the list of those who have access – "US Department of Health and Human Services, HCQU Nurses and when necessary, Certified Investigators".

6100.81 HCBS provider requirements – Comments and Suggestions – (a) Delete this statement and replace with

(a) " New HCBS providers must complete and submit the following completed documents and verification to the Department prior to providing HCBS:

(1) a provider enrollment application, on a form designated by the Department

(2) A medical assistance provider agreement, on a form designed by the Department

(3) A home and community-based waiver provider agreement, on a form specified by the department

(4) Verification of compliance with 6100.81(2)

(5) Verification of compliance with 6100.6

(6) Documents required in accordance with the Patient Protection and Affordable Care Act

(7) Verification of successful completion of the Department's pre-enrollment provider training as specified in 6100.142

(b) Enrolled HCBS providers must maintain:

(1) Copies of current licenses, as applicable and as specified in 6100.81(2) and

(2) Verification of compliance with 6100.46

(c) The Department shall timely review and shall approve completed applications to provide HCBS.

The proposed regulatory text was deleted and new text is proposed for purposed of clarity and fairness.

6100.82 HCBS Documentation – Deleted entire section – the central aspects of this section can be easily consolidated into section 6100.81. It is recommended that this section be deleted and core aspects be streamlined and combined in to section .81

6100.85 Ongoing HCBS provider qualifications – this section should be redrafted to read – "(a) A provider shall comply with provisions of applicable HCBS waivers, State Plan and amendments thereto, as the provisions of those waivers and the state plan are reflected in valid state regulation. (b) The providers' qualifications to continue providing HCBS will be verified at intervals, as applicable. Deleted (c) (1) (2)(3) (4) and add "(c) Providers may not employ, contract with or governed by a person or persons listed on the Federal or Commonwealth current applicable lists of persons excluded from participation in the Medicare and Medicaid program. Delete (d) (1) (2) (3).

Comments and suggestions – Above listed suggested texts is added to assure consistency with state law regarding the applicability and enforcement of agency policy and procedures through the adoption of regulations. An agency's mandates that are expressed in the form of duties and obligations are null and void absent compliance with the Commonwealth's rulemaking process.

6100.141 Annual Training Plan – Comments and Suggestions – Delete (a) as written and replace with "The provider shall design an annual training plan based on the needs specified in the individual's PSP and the prover's quality improvement strategy. Retain (b) and (c) and replace

(d) with " The plan shall address the need for training in such matters as rights, facilitating community integration, honoring individual choice and supporting individuals to maintain relationships. Delete (d) (1) and (2) (e) and (f). Replace (e) with "The plan shall explain how the provider will assure that staff understand their responsibilities regarding the promotion of individual rights and the reporting of suspected rights violations, abuse or neglect in accordance with the regulations that define those rights and responsibilities. Replace (f) with "The plan shall explain how the provider will assure that staff understand the safe and appropriate use of positive interventions, including the training in the plans which are unique for any one person served. ADD (g) The plan shall include paid staff with client contact ADD (h) The annual training plan shall include the following (1) title of the position to be trained and (2) the required training coursed including the training course hours for each position. ADD (i) Records of orientation and training including the training sources, content, dates, length of training, copies of certificates received and person attending shall be kept. ADD (J) the provider shall keep a training record for each person trained.

Suggestions – The purpose for a training plan is defeated by the idea that specific subjects or specific number of hours will address the needs of the clients or the organization. The training plan must be created based on an assessment that is, by definition, unique to the individual. As provider organizations analyze the needs of the people they support, the knowledge created in the field and their assessment of performance, a flexible, customized, quality focused plan will emerge. This new section collapses the critical elements of section 141 and 143 into one streamlined and accountable set of standards to not only maintain the basics, but to advance our work to the next level.

Interns and volunteers should not be included as required to go through the training process. The interns and volunteers are time limited, and additionally, the information they need should already be included in the orientation.

1600.142 Orientation Program – Delete (a) as written and replace with "Within 30 days after hire, and prior to working alone with an individual, the following persons shall complete the orientation program as describe in subsection (b) -

(1) Management, program, administrative and fiscal staff person
(2) Dietary, housekeeping, maintenance and ancillary staff persons
(3) Direct support staff person, including full-time and part-time staff
(4) Household members who will provide a reimbursed support to the individual.
(5) Life sharers
(6) Volunteers who will work alone with individuals
(7) Paid and unpaid interns who will work alone with individuals
(8) Consultants who will work alone with individual, except for consultants such a clinicians who are licensed by the Commonwealth of PA or other states."

ADD "(b) The orientation program must encompass the following areas: Deleted (1) as written and replace with

"(1) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with the Older Adults Protective Services Ace, The Child Protective Services Law and the Adult Protective Services Act.
(2) Individual rights
(3) Recognizing and reporting of incidents."

ADD (c) Within 30 days after beginning employment and prior to working alone with an individual, the following person shall also complete orientation training that incorporates application of person-centered practices; such as including respecting rights, facilitating community integration, honoring choice and supporting individuals in maintaining relationships:

(1) Management, program and administrative staff person (DELETE fiscal staff)
(2) Direct support staff persons, including full and part time.
(3) Household members who shall provide a reimbursed support
(4) Life sharers

(5) Records of orientation training, including the training source, content, dates, length of training, copies of certificates, and persons attending shall be kept.

Comments – The proposed edits focus on reducing the need for certain training in different levels and on protecting the individuals. They otherwise limit the extensive training requirement for certain positions. This section is geared towards licensed providers – payment rates may have to be adjusted. Also, looking at what is currently written in (b)(1) The application of person centered practices, including respecting rights, facilitating community integration..... should be deleted, at a minimum, for fiscal staff, dietary, housekeeping, maintenance and ancillary staff persons. This increases the costs while not impacting on the health, safety and welfare of the individuals as these positions don't interact with clients in the same manner as others listing in this area.

1600.143 – Annual Training – Delete this section as written – There is no purpose to the mandate of hours to any set group of employees. The provider is knowledgeable regarding specific training requirements for the staff in their agency. When there are established mandates to hours versus individuality, the service quality and the opportunity to support the values of ODP and Everyday Lives is lost.

To mandate the training require of 12 hours annually for fiscal, dietary, housekeeping, maintenance and ancillary staff would add an additional cost of $13,800.00 to this provider.

Additionally, current rates to not support the increase in training requirements for unlicensed services. To mandate 24 hours of annual training to staff that provide intermittent Companion and Home and Community Habilitation to individual living in the community with family members or independently will greatly increase current costs and there is no reimbursement method to get reimbursed as authorized units are for direct service only and the rates are pre-established. This requirement will cost this agency and additional $36,600.00 to provide 24 hours of training to 77 contract staff persons.

6100.181 – Exercise of Rights – Delete draft (c) (f) (g) as it is redundant or otherwise unnecessary.
6100.182 – Rights of the Individual – Proposed language should be:
(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.
(b) An individual possesses all the civil, legal, and human rights afforded under law.
(c) An individual has the right to be free from abuse, neglect, mistreatment, exploitation, abandonment or be subjected to corporal punishment.
(d) An individual has the right to make informed choices and accept personal risks that do not pose a threat to the individual's and/or another person's health, safety, or well-being.
(e) An individual has the right to refuse to participate in activities and supports.
(f) An individual has the right to control his/her own schedule and activities in accordance to their PSP.
(g) An individual has the right to choose a willing and qualified provider.
(h) An individual has the right to assistive devices and support to enable communication at all times.
(i) An individual has the right to participate in the development and implementation of the PSP.

6100.183 – Additional rights of the individual in a residential facility – Discussion (e) It is a positive to state that the individual has the right to choose with whom to share a bedroom, when there is a vacancy in a 2 person bedroom, there isn't always the ability to offer choice to the individual who is in the bedroom of a potential roommate. While we don't want to deny an individual his/her right to choose who to share a bedroom, I'm not sure how a provider can guarantee this in every situation. Suggestion: Reword (e) to state: "An individual has the right to request a change of room or a change of provider if not satisfied with current bedroom roommate".

6100.186 – Role of family and friends – Comment: The wording makes it seem like the individual's desire is paramount without taking into account that an individual can want something that is not healthy or have unhealthy relationships, i.e. a family member who has in the past exploited the individual

financially. Suggestion: Include a statement that allows for the input of the Team to determine when contact with friends/family may impact the health, safety and welfare of the individual.

6100.221 – Development and Revisions of the PSP – Comment: (b) states that the service implementation plan must be consistent with the PSP – What is the "service implementation plan"? This is not defined in draft language. Suggestion: Define Service implementation Plan.

6100.222 The PSP Process – Delete draft items (b) (7) (8) (9) (10) (11) Comment: these items are not necessary as the format developed by ODP should reflect (7) & (8). The provider has agency policies as should the SC to address (9) and (10) and should not be contained in this section.
Deleted this section and put items (a) (b)(1 through 6) in 6100.221 PSP development.

6100.223 – Content of PSP – Delete (12) Education and learning history and goals – If an individual is 55 years old, how relevant is this information? Additionally, skill development from past education/goals would be captured in the assessment. Reword (13) to be "Health Care Providers" Delete health care history as that is also captured in the assessment. Delete (16) and (17) as unnecessary.

6100.226 – Documentation of Support – Comments Item (b) What is service implementation plan? The requirements in (4)(6)(7) is excessive when applied to residential and adult day settings. Current practice to document on outcomes on a data sheet, thereby verifying that the outcome is being worked on and progress noted, is sufficient to meet CMS requirements. The outcomes are monitored and monthly notes on progress/lack thereof is noted and quarterly reviews by program specialists complete the documentation requirements. The desire of ODP to provide person centered services is jeopardized with these extensive documentation requirements as staff will be spending more time on documentation and less time with the individuals.

For individual who reside in the community and receive companion service or home and community habilitation, and for those receiving behavioral support services, all of the draft documentation requirements are current practice. As the service may only be delivered 4 times a month for 2 hours, it makes sense to document all of the information contained in (4) (6) (7) to support billing and time/attendance records of the agency.

Currently there is no process in place to complete 3 month reviews on all of the ISP of individuals who receive companion and home/community habilitation services. We currently serve 88 individual who live in the community with family and who receive intermittent services. To add the requirement of 3 month reviews for intermittent services would require the addition of a 30 hours a week staff person to the administrative staff, for a cost of an additional $27,000.00.

Recommendation: ODP should eliminate item (4) (6) (7) for residential, adult day, AIS and Supplemental HAB. Documenting on data sheets when working on specific outcomes and a monthly summary of progress, as is current practice is more meaningful and appropriate to the services and is meeting CMS requirements.
ODP should retain requirements in items (4) ((6) (7) for those services that are delivered intermittently, i.e. companion services.

There also needs to be clarity from ODP in defining the PSP, Service Implementation Plan and Support Delivery. In definition section a "support" is an activity, assistance or product provided to an individual through specific funding streams. A "support" is also defined as services. So for example, in residential what is the documentation requirement, is it documenting daily on all of 610.226 (a) (b) (c) (d) (e 1-7)? Needs clarification!

6100.261 – Access to the community – Discussion – (c) the individual shall be afforded..... Statement. How does ODP plan on measuring this statement? Who decides the "same degree of access" when it is an individual's preference on access?

Suggestion: ODP took the statement in (c) from CMS final rule but needs to clarify how this will be measured. Additionally, the individual must have access to the community; this is not only a right that must be supported, but a requirement of the Community Rule. As a provider we fully support this initiative and have been attempting to maximize access for individuals. ODP must provide the financial and policy support to ensure success. ODP must recognize and accept responsibility and ensure that there is essential funding for the individuals to access the community. Especially when it comes to individuals who use wheelchairs for mobility or have challenging behavioral issues.

6100.341 – Use of Positive Intervention – Discussion – The terminology change from Restrictive Procedure Plan to Positive Interventions is a great improvement in this section. It appears that only individuals with "dangerous" behaviors will have as a part of their PSP, methods of supporting the individual. These proposed regulations appear to eliminate the need for Behaviors Supports and a specific support plan for all other individuals who may have some behaviors concerns but are not considered dangerous to themselves or others BUT for consistency purposes, need as par of their PSP a written method for supporting the person when the behavior(s) occurs.
Recommendation: (a) add to the statement ..... eliminate a dangerous behavior or a behavior that the individual's team believes has the potential to be dangerous, when the behavior is anticipated or occurring. Some individuals require the support of a behavioral specialist even if their behavior is not "dangerous" at this time. There is a concern that only individual with "dangerous" behaviors will be authorized to receive services from a behavioral specialist.

6100.343 – PSP – Comments: This area should be deleted and rolled into 6100.223

6100.343 – Prohibition of Restraints – Comments: Geriatric chairs are utilized as an option to reposition individual who sit in wheelchairs all day. Geriatric chairs are sometimes the only "approved" option for repositioning of an individual who has severe osteoporosis, etc.
Suggestion: remove all definitions to 6100.3 and delete geriatric chairs from the list of mechanical restraints OR reword as "geriatric chairs without an order from a medical professional or physical therapist.

6100.345 – Access to or use of an individual's personal property – Comment There are some individuals who understand the consequences of making restitution for damage to others' property. In these cases, there should be a mechanism for this natural consequence to occur, such as a team approved proposed plan, restrictive procedures review committee review/approval, etc. The regulation must tak into account legal orders secondary to adjudication of conviction of a crime that results in the need for some type of restitution.

6100.401 – Types of incidents and timelines for reporting – Comments and Suggestions: Reword (a) to read "A provider shall report the following incidents/alleged incidents through the Department's information management system within 24 hours of having knowledge of the incident:
Delete from the list (13) (16) and delete (17) altogether (what does that even mean?)
(b) Reword to "A provider shall report the following in the Department's information management system within 72 hours of having knowledge of an incident: (1) Medication administration error and (2) Use of a restraint outside the parameters of the PSP"

(d) this statement needs to include as redacted information – the "target of the incident (when one is listed). Even though only the target's initials and last 4 digits of SS# are used, in the case of a community home, where there are limited staff, listing initials can easily identify the target of the investigation. Target information must be redacted along with the others listed. Giving information regarding the target could be damaging to the staff person and his/her relationship with the individual/family. This is especially crucial when in a situation that the certified investigation proved that the abuse was unfounded. If the result of the investigation is founded and sharing that information with the individual/family could also put the staff person at risk as one can never know how the family would act

or react to the target and the situation is also a personnel issue and these issues are never shared with families.

6100.402 – Incident Investigation – Discussion: Item (c) the proposal to require ALL incidents to be investigated by a Certified Investigator is a colossal waste of staff resources and will not ensure to any greater degree, the health, safety and welfare of individuals receiving services.

Currently, in this agency, administrative/supervisory staff have become CIs and are assigned investigations on a rotating basis. Should EVERY incident require an investigation by a CI this agency would need to hire 2 full time employees to comply with this regulation, which would cost and additional $60,000.00 for this agency. This increase in costs and the requirement of a CI for all investigations will not provide more protections for individual receiving services.

Additionally, with the increase in number of investigations there will be an increase in the number of Peer Reviews. This demand for the increase in paperwork/review/staff time, etc. will not provide any additional assurances that individual's health, safety and welfare is any better protected.

Finally, in the current system of Incident Management, every incident goes through 2 additional reviews; the 1st is by the AE and then ODP Regional staff review. Should concerns arise regarding any of the reported incidents, it is immediately addressed. There is no need for CI to "investigate" every incident that occurs.

Suggestion: ODP must keep in place the current system of designation of incident as those requiring an investigation. CMS does not require a certified investigation of every incident.
Item 6100.402 (b) should read: The provider shall initiate a certified investigation within 24 hours of the occurrence or discovery of the following incidents:

(1) Death
(2) Abuse
(3) Neglect
(4) Exploitation
(5) Individual to individual sexual abuse or serious bodily injury
(6) Person missing for more than 24 hours (or if missing at puts the individual at risk)
(7) Theft or misuse of individual's funds
(8) Rights violations
(9) Unauthorized or inappropriate use of a restraint

6100.403 – Individual needs – Comments: Section (a) (1 through 8) and (b)– Currently when investigating an incident, the CI takes all of these items into account when completing a thorough investigation. What is the purpose of this additional review when ODP is training CI to review all of this during the investigation?
How will licensing monitor this requirement that "the provider shall review and consider the following needs of the affected individual"?
(b) There is a process in place for provider administrative review prior to the completion of an investigation whereby corrective actions are recommended and documentation of the corrective action when completed.

Suggestion: ODP should delete this entire section from regulation as this review occurs outside of regulation, during the investigative process.

6100.405 – Incident analysis – Discussion: All of the elements in this section are unnecessary for ALL incident reports. For the incidents that currently require an investigation, most, if not all, of these components in this section are completed. To require documentation identifying and implementing

preventative measures for hospitalizations, ER visits due to illness will not prevent these incidents from occurring in the future. As an example: several individuals we provide services to have uncontrolled seizure disorders and have an order for Diastat (rectal valium). These doctor's orders typically read: if the seizure lasts longer than 3 minutes after the administration of Diastat, call 911 and transport to the ER. The provider can complete all the steps listed in this proposed regulation and never be able to prevent future incidents of this type from occurring.

Should the requirements remain in this section, this agency would need to hire a 20 hour a week staff person to continuously analyze the data on all incidents. These requirements of investigation on all incidents and the detailed analysis, required ongoing and quarterly will require the development of a Risk Management Team within this Agency. In addition to the 2 full time staff that we would need to hire to meet the requirements of item 6100.402, the requirements in this proposed regulation would add the additional cost of $25,000.00 for the part time staff person.

Recommendation: ODP eliminate (a) (1) (2) (3) for ALL incidents and retain for those that currently require an investigation (suggested list in 6100.402).
Item (b) – ODP should retain this requirement for a quarterly review of all incidents
Item (c) (1) (2) (3) – ODP should retain this requirements for those incidents that require an investigation
Item (d) – retain this requirement
Item (e) eliminate this requirement as there is a quarterly review of all incidents.

6100.441 Request for and approval of changes – Comment and Suggestion: There are many situations within which individuals would benefit from rapid placement. These situation include natural disaster, program closures, and removal from abuse. It is important that this chapter allow for an expedited capacity change process to accommodate individuals' needs in their everyday lives.

6100.443 Access to Bedroom and the home – Comments: (a) delete as written and replace with "Each individual has privacy in their individual sleeping or living unit. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
(e) delete as written and replace with "The rights of the individual to privacy in his/her bedroom should be respected in accordance with 6100.181-183, with consideration for the needs of the health, safety, and welfare of the individual as determined as part of the assessment process and incorporated as part of the PSP, or as needed in an unforeseen or emergency circumstance.
(f) delete as written and replace with "Provider staff should request permission whenever possible and if the person has capacity to give consent, when entering a bedroom in circumstances other than a health and safety issue.

Suggestion: While we understand the purpose of the Community Rule, one would question the application of the Rule when an individual has not understanding of what a key is and it's usage, and has such has no meaningful use for a key or locked bedroom, as well as the capacity to understand the request for permission to enter their bedroom. ODP should insert language into this regulation that would make, as part of the assessment, the individual's capacity to give consent and to utilize a key.

6100.444 Lease or Ownership (Suggestion – change to Occupancy) Comment: (a) Delete as written and replace with "In residential habilitation, the individual shall have a room and board agreement.
(b) Delete as written and replace with "Providers may establish reasonable limits for the furnishings and decorating of living units as long as the limits are not discriminatory and do not otherwise deny rights granted to individuals under applicable laws and regulations.

Suggestion: It is necessary under the Community Rule that individuals have a legally enforceable document that offers the same responsibilities and protections from the eviction as our prevailing laws. To that point, 6100.444 (a) is clear and direct. 6100.444(b) while describing reasonable limits, inadvertently refers to providers as "landlords" and to individuals as "tenants" and their units as "leased space". The rights conferred under the rule and as cited in 6100.444(a) do not make providers landlords.

Having the same protections as provided by law does not make individuals tenants nor their spaces "leased". This language distinction is important in that we need to preserve the American Disability Act's protection of community residences as homes rather than businesses which can be excluded from residentially zoned area. This distinction will also be crucial if/when the state develops guiding language or uniform formatting for the residency or room and board agreements in the future.

6100.446 – Facility characteristics relating to size of facility – Comment: (b) (1) (2) (c) (1) (2) – delete all of these sections.

Suggestion: A movement of a residential facility must be approvable upon a reasonable demonstration of comparability of service provision and cost.

The Community Rule does not specify an absolute cap on program size. Smaller size programs require additional staffing levels, additional facility costs, and contribute to the workforce shortage. (DHS itself has recently approved larger census programs for individuals with medical needs.) Federal regulation expressly provides: "We do not believe there is a maximu7m number that we could determine with certainty that the setting would meet the requirements of HCB setting. The focus should be on the experience of the individual in the setting."

Medication Administration - there are two important issues concerning the proposed new regulation pertaining to medication administration.

(1) Codifying content that requires modifications over time into regulation will lock a crucial component of service provision into temporal practices which will become obsolete as new information ,prevailing practices and technology emerge. Duplicating content which is as detail-specific as the proposed five-and-a-half pages of regulation across 5 sets of regulations when the state already has an externally- accepted training module invites discrepancy between the regulations and the training manual and prohibits the training module from staying current as new information, prevailing practices and technology emerge.
(2) Requiring 6500 LifeSharing providers to complete and adhere to ODP's Medication Administration Module is a new and counterproductive requirement which is in direct contract to Everyday Lives principals and the Department's stated intent to develop more integrated and natural life opportunities for individuals.

As a ready example of the problem with codifying material which requires change over time, an area has been identified in which the proposed regulations are at odds with prevailing practices as detailed by Title 49 of the State Nursing Board. 49PA.CODE CH.21 explicitly provides for Licensed Practical Nurses to accept oral orders for administering medication. The proposed 6100.465 provision only allows this practice for Registered Nurses.

This discrepancy is instructive both to the specific issue regarding LPN/s and to the process issue of codifying Nursing Practices content which changes from time to time according to authorities outside the Department. It is noted that the provider system needs LPN's to be able to do all that state law provides for them to do. In the second case, we need regulations which do not lock providers to standards which may soon become obsolete.

A second example of the problem with trying to maintain this content in multiple places is that there are already discrepancies between the proposed 6100's and the Department's Approved Medication Administration Training. The training's required checklist for medication self-administration has discrepancies with the proposed regulation. There is also a notable practice discrepancy regarding pre-pouring of medications. We should avoid such confusion by requiring compliance with the most current version of the Department's approved Medication Training module.

6100.466 – Medication Records – Suggestion to delete the entire section and replace with:
(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered, and the name of the person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer.
(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication
(c) A list of prescription medication, the prescribe dosage and the name of the prescribing physician shall be kept for each individual who self-administers medication.

General Payment Provisions
6100.481 – Department Established HCBS rates – Suggestion: delete (a) (6) (b) (c) (d)
Discussion – As drafted, the proposed section .481 references the standard and traditional means by which the Department pays for medical assistance covered services. Contrary to the Department's explanation of the purpose of the regulation, the regulation itself does not create "an array of payment options". The options enumerated have existed since the inception of the Department's Medical Assistance Program. Indeed, the use of managed care as an alternative to Department established fees (whether fee schedule based or cost based) is expressly authorized in statue 62 P.S. 443.5. So, although framed as a regulation, this section essentially does no more than restate existing payment for service options already available under federal and state law.

The regulation, at 6100.481(b), is contrary to federal law when it purports to authorized the Department to "establish" an HCBS fee merely by "publishing a notice in the Pennsylvania Bulletin." This section, read in conjunction with proposed regulations at 6100.571 (a) (c) (d) and (e) will enable the Department to establish rates apart from and without compliance with an approved rate setting methodology that explains, under its proposed "market basket approach" (.571(a)) the actual factors relied upon in setting the rates, how the factores were actually developed and utilized in setting the rates, and the basis for any assumptions relied upon in setting the rates.

Under the proposed .571(c) the Department explains how it will "consider" (in contrast to utilize) a list of generic "factors" to create its "market based data" to establish fee schedule rates. Among the referenced factors are "staff wages" and "staff related expenses" and "productivity" and "administration related expenses". Specifics regarding these and the other "factors" are notably excluded from the regulation. Equally inappropriate, the factors include "determinations made (by whom?) about cost components (such as?) that reflect costs necessary and related to the delivery of each HCBS (.571 (c) (8). How this review might be accomplished and precisely what costs will be considered as "other criteria that impact costs". In other words, whatever undisclosed factor(s) the Department may elect to apply.

This fundamental lack of specifics and commitment to assuring that payment rates and service costs are fairly and reasonably aligned cannot be understated. Pennsylvania's ability to provide necessary supports and service to over 50,000 Pennsylvanians with an intellectual disability or autism depends on fair and rational rate methodology. The Medical Assistance Program is the sole payer of ID services in PA and Medical Assistance eligible clients comprised 100% of the HCBS population. The state and federal governments have recognized that the principal cost driver for ID/A services is the workforce, account for approximately 80-85% of the total HCBS costs and that workforce stability is threatened by the inability of providers to offer competitive, family sustaining wages. High staff turnover and vacancy rates, in turn, impact access to and quality of care.

The Department's regulations reflect an unfortunate misunderstanding of the constraints that apply to its HCBS rate setting duties and obligations. That misunderstanding is evident in its response to paragraph (9) of the IRRC Regulatory Analysis Form that asks the Department to identify state or federal

law or court order that mandates the adoption of the proposed regulations and whether "there are any relevant state or federal court decision" to consider. The Department responded that: (1) the HCBS regulations are mandated by 42 C.F.R. 441 Service Requirements and Limits Applicable to specific Services" and (2) "there are no relevant court decisions".

The Department's responses ignore applicable federal and state statute and case law that prescribe the requirements that the Department must adhere to in establishing payment rates for HCBS services. The fact that HCBS regulations and payment rates relate to "waiver programs" does not excuse the Department from compliance with the federal statues and case law cited herein nor, of course, with its separate responsibilities to comply with state statue and relevant state case bases.

Under 42 U.S.C. 1390 a(a) (13) (A), the Department must provide public notice of the methodologies that underlie the rates that it proposes to adopt.
In developing and adopting HCBS payment rates, the Department is compelled to comply with the requirements of 42 U.S.C. 139(a) (a) (30)(A) that directs it to adopt "methods and procedures" that assure that "Payments (to providers) are consistent with efficiency, economy and equality of care and are sufficient to enlist enough providers to assure access to HCBS providers by waiver program eligible individuals."

6100.482 – Payment for HCBS services – Comment: Deleted (i) from draft regulation
The Department is obligated to pay for HCBS services consistent with the provisions of this chapter 6100. To the extent that the Department seeks to impose any of the provisions of "waiver amendments" or the state plans as mandates, those provisions must be adopted as regulations in accordance with the Commonwealth's regulatory review and approved process.

6100.485 Audits – Comments: Delete from the draft (3) (4) (b) (c) (1) (2) (3) (4) (5) (6) (d) (e) (f) (g) (g)(i) and (j) Providers have the right to know the precise standards that will govern an audit of payments received under this Chapter 6100. Explain the Department's policy and legal justification for imposing so many different standards on HCBS providers. What other Provider type is subject to so many different audit standards?

What is the purpose of requiring costly audits of a fee schedule rate based payment system?

6100.571 Fee Schedule – Comments: (a) reword this item to read: Fee schedule rates, which include fees for residential ineligible services, will be established annually by the Department.
(b) delete as written and reword to read: For Fiscal Year 2017-1018 the Department shall apply the Medicare Home Health Market Basket Index to each fee schedule rate for each ear from FY 2012-2013 through FY 2017-2018 to establish the FY 2017-2018 Fee Schedule Rates.
Delete (c) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Add (c) On or before May 1, 2017 the Department shall publish in the Pennsylvania Bulletin a notice that (1) identifies the FY 2017-1018 Fee Schedule Rates; (2) explains in sufficient detail the FY 2017-2018 rate setting methodology and (3) solicits public comments for 30 days.
Delete (d) (e)
Add (d) On or before September 1, 2017, after review and consideration of the public comments it received, and consistent with subsection (b) above, the Department, by publication of notice in the Pennsylvania Bulletin, shall publish in final FY2017-2018 Fee Schedule Rates and rate setting methodology along with its responses to each comment received regarding the proposed Fee Schedule and methodology.
Add (e) For FY 2018-2019 the Department shall update the cost data base it relies on to establish fees so as to reflect providers' current cost experience and rate setting methodology that it relies on to establish the FY 2018-2019Fee Schedule Rates to include the application of the Medicare Home Health Market Basket Index applicable to FY 2018-2019.
Add (f) The Department shall annually update the cost data that it relies upon to establish Fee Schedule Rates.

Add (g) In every fiscal year after 2017-2018, the Department shall follow the process and procedures describe in subsections (c) above relating to the publication of proposed and adoption of final Fee Schedule Rates.

Suggestion: The proposed regulations reflect a statement of intent as opposed to establishing an enforceable standard of practice by the Department and fails to explain the precise methodology that ODP will actually relay upon to establish payment rates. ODP's proposed text essentially carries forward the WORST elements of Chapter 51 – vagueness, unfettered discretion and lack of an affirmative duty to establish payment rates consistent with federal law. These proposed amendments reflect adherence to aligning payments with allowable costs incurred by providers to meet the documented needs of Waiver Program consumers.

Providers are entitled to predictability, reliability, and accountability in the rate setting process. Reliance on statements about "review" and "consider" along with the vague reference to "criteria that impacts costs" are too imprecise and contrary to the Departments legal obligations.

6100.647 Allowable costs – Suggestion – Add this language; "Allowable costs are documented costs that in their nature and amount are costs incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs and are ordinary and necessary costs for the provision of HCBS as prescribed in this Chapter.
Delete all other parts of this draft section.

6100.648 Donations – Comments: Delete this entire section!
In a single payer system, which does not reimburse a Provider's full allowable cost, why does the Department seek to impose limitation on donations? How is this remotely equitable?