Summary of Comments and Department Responses
10-144 Chapter 101, MaineCare Benefits Manual, Chapters II & III, Section 107,
Psychiatric Residential Treatment Facilities

The Department of Health and Human Services held a public hearing on Monday, May 21, 2018 to obtain public comments on proposed rule changes. Written comments were accepted through Thursday May 31, 2018. This document combines, summarizes, and responds to all the comments received during the public comment period ending Thursday, May 31, 2018.

List of Commenters:
Commenter 1: Regina Masters
Commenter 2: Dr. Lindsey Tweed
Commenter 3: Nancy Cronin
Commenter 4: Shannon Johnson
Commenter 5: Mara Sanchez
Commenter 6: Jenna Mehart
Commenter 7: Meagan Sway
Commenter 8: Alan Kurtz
Commenter 9: Peter Rice
Commenter 10: Cathy Dionne
Commenter 11: Jill Ward
Commenter 12: Maine Inside Out
Commenter 13: Mary Bonauto
Commenter 14: Mallory Shaughnessy
Commenter 15: S. Osgood
Commenter 16: The Association for Maine Behavior Analysts (AmeBA)
Commenter 17: Lydia Dawson
Commenter 18: Kim Humphrey
Commenter 19: Christine Tibeault

General Comments:

Commenter 1:

1. Commenter one would like to propose before children can have the services of HCT the parents are required to participant in formal parenting classes.

Response:
The Department thanks the commenter for this comment, but this is outside the scope of this rulemaking.

Commenter 2:

2. Commenter 2 commended the Department for addressing the four urgent needs described in the preface to this proposed rule: youth in out-of-state placement, youth stranded in psychiatric hospitals, youth stranded in Emergency Rooms (ER's), and youth with behavioral health needs who are incarcerated. These are some of the most challenged and challenging youth in our state, and it is crucial that DHHS pursue its goals of ensuring them adequate treatment. Commenter 2 stated he is very happy that DHHS is addressing this urgent problem.

Response: The Department thanks the commenter for this comment and appreciates the support for this rulemaking.

3. The commenter reviewed the approved diagnoses and suggested some were missing, including developmental disability diagnoses, disruptive mood disorders, conduct disorders, and attention deficit hyperactivity disorder (ADHD).

Response: The Department thanks the commenter for this comment. A prospective member's primary diagnosis must be a diagnosed psychiatric condition, as described in Appendix A, but it does not preclude a member with comorbid intellectual or developmental disabilities. Appendix A includes Disruptive Mood Dysregulation disorder, as such the Department is unsure what else the commenter believes could be missing as a disruptive mood disorder. ADHD has been added to the Appendix A given that most youth approved by the Clinical Certification of Need Team will have several other diagnoses as well.

4. The commenter stated that 107.05-01 specifies that the amount and intensity of treatment should be higher than that in a Section 97 Intensive Temporary Residential Treatment (ITRT) program and approved. However, the commenter believes that the section does not have any mechanism to ensure that evidenced based or best practice models are used. Additionally, the commenter stated that there does not seem to be any mechanism to monitor, ensure, and improve quality. There does not seem to be a mechanism to monitor and improve outcomes.

Response: The Department thanks the commenter for this comment. The Department understands the importance of using evidence based practices and national standards of treatment. This policy attempts to balance the use of evidence based practices while allowing clinicians the flexibility to determine clinically appropriate interventions. In determining whether to certify a PRTF, one of the items CMS reviews is adherence to the National Standards of Treatment. There is a rigorous admission process and the Department intends to monitor CANS scores to survey service effectiveness. The licensing rules also require PRTFs to establish and maintain quality assurance procedures.

5. The section requires two hours weekly of family therapy, which is excellent. We don't know the geographic distribution of PRTF's; family may be far away. There will need to be some mechanism to use televideo.

Response: The Department thanks the commenter for this comment. The Department allows services to utilize telemonitoring when clinically appropriate. Please see Chapter I Section 4 Telehealth rule for more information on accessing telehealth services.

6. The Department proposes a rigorous admission process--this is certainly very appropriate for such a restrictive level of care. The preface lists youth stuck in ER's as a target group. We certainly do have youth in ER's who are unsafe to go home and who our psychiatric hospitals will not admit. Is it anticipated that the certification process will be able to be done out of an ER?

Response: The Department thanks the commenter for this comment. The proposed rule does not specify any specific setting for the Clinical Certification of Need process to be completed. The CCON may be completed in any setting that is clinically appropriate for the member. No changes were made to the final rule.

7. In reviewing the Eligibility Requirements in 107.04, it is difficult to see the Department's overall approach to eligibility. PRTF's, being locked, are more restrictive than ITRT's; they presumably are for youth who cannot be safely or effectively treated in ITRT's. The PRTF's and ITRT's need to function as a seamless continuum of care for our most challenged youth. We recommend criteria that more clearly and specifically focus on this principle.

Response: The Department thanks the commenter for this comment. Please note that 107.09-01(E) prohibits locked seclusion.The Department reviewed the eligibility and certification requirements for PRTF and believes the eligibility criteria are quite proscriptive as described in 107.04-02.B . The Department is concerned that adding more specific eligibility criteria could unintentionally preclude members from receiving the service when it is medically necessary. The Department placed significant emphasis on the discharge planning process in order to assure adequate continuity of care upon discharge. No changes were made to the final rule.

8. 107.04-02.B.1.b states that ambulatory resources do not meet the youth's treatment need; we recommend changing this to an ITRT not being able to meet the youth's need.

Response: The Department thanks the commenter for this comment. The Department reviewed this request and determined that such a requirement would be too restrictive. There are many individuals who are too acutely ill to be placed in an ITRT or whose psychiatric needs are such that an ITRT is otherwise contraindicated. The Department does not wish to preclude these members from accessing PRTF services. However, we have added language to the 107.04-02.B.1.b stating "including Private Non-Medical Institutions" as a consideration prior to requesting PRTF services in the final rule.

9. Youth must meet one of the 3 criteria listed in 107.04-02.B.1.b. The first is basically danger to self, and the 2nd is danger to others--these make a lot of sense. The 3rd is need for continued treatment beyond the duration of an acute care hospital and documented evidence an appropriate intensity of treatment cannot be provided in a community setting. This presumably means that youth who are not dangerous to self or others but who are stuck in a hospital will be eligible--this does not seem high enough a bar for a locked facility such as a PRTF.

Response: The Department thanks the commenter for this comment. Please note that 107.09-01(E) prohibits locked seclusion.The Department believes that given all the additional requirements for this service the criteria is adequate. To be eligible, members must display at least four of the symptoms outlined in 107.04-02-B.1.a.iii (described below) along with an active psychiatric condition and demonstration of behavioral abnormalities. The Department feels these requirements adequately safeguard against placing a member in a PRTF simply because no other service is available. No changes made to the final rule.

107.04-02.B.1.a.iii:

a. failure to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;

b. failure to demonstrate or maintain developmentally and culturally appropriate peer relationships;

c. failure to demonstrate a developmentally appropriate range and expression of emotion or mood;

d. disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreation settings;

e. behavior that is seriously detrimental to the youth's growth, development, safety, or welfare, or to the safety or welfare of others; or

f. behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

10. The purpose of 107.04.B.1a..iii is difficult to see. It lists 6 requirements, 4 of which must be met for admission; many of the items are examples of the youth's behavioral health problem impacting his/her functioning. Many youth in outpatient treatment would meet 4 of these criteria. We think this low bar criteria section is potentially confusing and can be removed.

Response: The Department thanks the commenter for this comment. Please see the Department's response to comment 9.

11. 107.04-02.B.1.d allows "to prevent regression" as a criteria. This is an important improvement, as past ITRT criteria could be read as excluding youth who weren't improving but were still too dangerous to be home. The last phrase "so that services will no longer be needed" is confusing. Does that mean until the youth can be safely and effectively served at a lower level of care (ITRT)?

Response: The Department thanks the commenter for this comment. The Department understands the commenter's concern. PRTFs are not intended to provider long-term care. The language allows for flexibility for youth to remain in treatment if gains are not immediate. No changes made to the final rule.

12. 107.04-02.B.1.c is tricky. It's hard to know which youth really need 24 hour nursing--it's hard to prove, for example, that a youth needs an RN overnight. The real need is for a locked facility; the extra medical treatment is required because the youth is in such a restrictive level of care. It seems important to avoid a situation where a youth can only be safely and effectively treated in a secure setting, but there is difficulty documenting a need for overnight RN care.

Response: The Department thanks the commenter for this comment. Please note that 107.09-01(E) prohibits locked seclusion. It is a federal requirement that PRTFs be staffed 24/7 by nursing. The eligibility requirements are intended to show the youth needs this level of care in general, but is not specific to individual practitioners. No changes made to the final rule.

13. PRTF's are a restrictive level of care; the youth in them will be very challenging. If ever the Department required treatment by a child psychiatrist, it would be at a PRTF. The commenter strongly recommended that medication management be provided by a child psychiatrist. When the Department specifies "psychiatrist", that allows for a general psychiatrist, almost all of whose training and experience is in treatment of adults. The commenter does not believe that Nurse Practitioners have the training to effectively treat youth with this level of challenge. Each member's planning team includes the medical director which includes a psychiatrist or MD/DO.

Response: The Department thanks the commenter for this comment. The Department agrees that in an ideal situation medication management would be provided by a child psychiatrist; however, the Department is aware that hiring child psychiatrists in the state of Maine is extremely difficult and believes that imposing such a requirement would make the PRTF service nearly impossible to offer. No changes made to the final rule.

14. The commenter strongly recommend removal of the phrase "Drug Used a Restraint (Chemical Restraint). The commenter stated that no medication should ever be used for the explicit purpose of sedation or reduction of mobility. To use a medication for such a purpose has been against clinical practice for decades. Incorporating this phrase in the rule, in our opinion, maintains outmoded

stereotypes of psychiatric treatment and maintains stigma. The term is outmoded and anachronistic, and it should be retired. There are, however, medications that can increase a youth's self control and that can be used on an as needed basis (sometimes called "PRN's"). We assume that is what the Department is actually trying to describe. The commenter suggested the following wording for Medication used on an as needed basis to temporarily support a member's self-control (PRN):

i. The medication is administered:

1. to assist a member in regaining self-control and restoring positive decision-making when those faculties are temporarily impaired to the extent of posing a safety risk to the member and/or others, or

2. to assist a member to regain reality-testing when that faculty is impaired by an acute exacerbation of psychotic, dissociative, or other symptoms.

ii. Is a pre-planned temporary intervention in the treatment plan

iii. Can only be administered by an appropriately licensed staff member acting within the scope of their licensure.

iv. Use of the PRN intervention more than once a day for three consecutive days indicates necessity for revising the treatment plan.

Response: The Department thanks the commenter for this comment. The Department agrees with the commenter that medication should only be used on an as needed basis "PRN." The Department has removed the definition in question to clarify that chemical restraints are not permitted in this service, and created a new section describing PRN medication and its uses for the final rule. The PRN provision clarifies that PRN medication may not be used as a form of restraint.

15. The commenter asked the Department to consider an RFP as part of a planned PRTF development process. The commenter stated that they do not have accounting or financial planning expertise, and cannot tell if the inclusion of capital costs in the rate setting process in Chapter III will be sufficient to induce providers to provide this service. If not, a supplemental RFP would help.

Response: The Department thanks the commenter for this comment. Federal Medicaid rules do not allow the service itself to be RFP. The Department included capital costs in the rate setting process and is described as allowable costs in chapter III. Providers will be reimbursed for allowable capital costs similarly to nursing homes. It will be paid as a prospective rate and cost settled through the audit process. No changes made to the final rule.

16. Please consider issuing an RFP for PRTF's; this will allow the Department to get the PRTF system it wants in terms of overall capacity, size of programs, specialization of programs, and quality of programs. There is a crucial additional benefit to an RFP: it would allow the Department to plan PRTF number, size, geographic distribution, and specialized services for special populations.

Response: The Department thanks the commenter for this comment. Federal Medicaid rules do not allow the service itself to be RFP. The Department must accept any willing and qualified vendor to perform the service. No changes made to the final rule.

17. For many of its children's behavioral health services, the Department uses an "any willing provider" approach, hoping that as each provider pursues its own interests, a coherent and effective

system will emerge. This may or may not work at lower levels of care; it is basically a disaster at higher levels of care. Consider our psychiatric hospitals, for instance: they each determine who they do and do not want to admit, and we thus have youth waiting for days and weeks in our ER's. MCCAP believes we do not want to recreate this kind of non-system with PRTF's.

Response: The Department appreciates the commenter's concerns regarding the system's adequacy for higher levels of care – because this is a State Plan service, the Department is precluded by federal rule from deviating from the "any willing and qualified" vendor. No changes made to the final rule.

18. Please consider the excellent example of DOC and Multisystemic Therapy (MST). As part of program rollout, DOC put issued RFP's that allowed youth and families access to a coherent, statewide system of MST teams. DOC has continued with ongoing contracts with the MST teams; this has allowed them to utilize performance based contracting, which we assume the Department cannot do with MaineCare funds.

Response: The Department thanks the commenter for this comment. Please see the previous response to comment 15. Federal Medicaid rules do not allow the service itself to be RFP. The Department appreciates the suggestion around performance based contracting. While the Department cannot issue contracts, the Department will consider performance-based payment options. No changes made to the final rule.

19. The Department has relied almost totally on MaineCare funding for children's behavioral health services--we believe this is, when compared to other states, a somewhat unusual approach. Always getting the Federal match may look more cost efficient in the short run. An over reliance on this approach, however, can lead to a system that is wasteful, low quality, and inefficient.

Response: The Department thanks the commenter for this comment. The Department appreciates the commenter's thoughts on this subject. As this comment period is specific to the PRTF rulemaking, the Department can only discuss this as a MaineCare reimbursable service. No changes made to the final rule.

20. Once again, we strongly commend the Department for acknowledging and addressing the lack of a secure treatment capacity for youth in Maine. We all are eager to drive the rate of institutionalization of youth--incarceration plus residential treatment--to the lowest rate possible. We want to be the equal of any state in the nation on that statistic. That rate cannot, however, safely be zero. We look forward to working with DHHS to develop secure residential treatment as a crucial part of our children's behavioral health system of care.

Response: The Department thanks the commenter for this comment. The Department agrees with the commenter's opinion. No changes made to the final rule.

Commenter 3:

21. The Maine Developmental Disabilities Council (MDDC) believes that with comprehensive, timely community supports most placements into residential facility can be avoided. By no means should residential treatment be the first line of treatment, it should only be used when all other treatment methods in a member's home has been exhausted. Maine should invest in its community system of care as its primary line of care.

Response: The Department thanks the commenter for this comment. The Department agrees that the PRTF should never be the first consideration as a treatment option for a child with a psychiatric condition. The Department understands and appreciates the commenter's concerns on the adequacy of community-

based treatment options available within the state. The Department does not believe that offering the PRTF service within the state of Maine is mutually exclusive activity from continuing efforts to improve the community-based services system in Maine. The Department believes that a secure treatment option is a crucial benefit for children who cannot be served in other settings.

22. The MDDC is very concerned that Section 107 is putting us back towards large institutional placements. Should Maine move forward with this model it should be for extremely short-term treatment until successful placements within the community can occur. The MDDC also believes that the system needs to provide a wide continuum of services to meet the wide variety of needs that children with DD have and that includes limited stays at residential centers for a variety of reasons but is opposed to using residential centers as long-term solutions.

Response: The Department thanks the commenter for this comment. The Department would like to clarify that members with a primary diagnosis of intellectual disability or autism, without an otherwise qualifying diagnosis would be precluded from receiving PRTF services. The Department believes that PRTFs are a medically necessary component in Maine's continuum of care. Only children who meet the strict criteria established in this policy will be referred to the PRTF. Additionally, PRTFs are intended to be short term placements and not long-term residential options. The Clinical Certification of Need process requires a review of service eligibility and medical necessity every sixty (60) days by design, which aids in preventing unnecessary institutionalization of children.

23. The commenter stated that 107.02-18 Serious Occurrence is unclear what "serious injury" means. Please define that term for clarity. Further, please amend the definition as follows "Serious Occurrence to mean a member's death, a serious injury to a member ~~and~~ or a suicide attempt by a member."

Response: The Department thanks the commenter for this comment. Serious Injury is defined at 107.02-16. The Department agrees with the commenter's suggested modification of the definition from "and" to "or," and has updated the definition for the final rule.

24. The commenter stated that Section 107.04-02.B.2.b, please include within medical finding clear evidence that the behavior the member is exhibiting is not due to an underlying pain or physical health issue before admitting. The language as written is not explicit enough to assure that pain is not the cause for an ongoing, or more sudden, behavior change.

Response: The Department thanks the commenter for this comment. The Department agrees with the commenter and believes that this is covered under 107.04-B.1.a.ii which states, "The member must also consistently and persistently demonstrate behavioral abnormalities to a significant degree, well outside the normative developmental expectations for the previous six (6) month period or must be reasonably predicted to last six (6) months. Behavioral abnormalities cannot be attributed to intellectual, sensory, or health factors."

25. The commenter stated that Section 107.07-04.E.1 Treatment Planning Team states that treatment planning be developed in consultation of the member's parents or legal guardian but the MDDC holds firm that parents and guardians should be active team members in planning and monitoring treatment plans of their child(ren). The treatment team should include, when the resident is a minor, the parent or his/her legal guardian. Please add an additional bullet that specifies that a team member must be, whenever applicable, a parent or legal guardian. It is a subtle difference, but while the proposed language acknowledges that the parent or guardian must be *involved* in the planning process it does not clearly dictate that the parent or guardian should have a designated,

equal seat as a member of the team. Having the parent or guardian be a member of the team is also consistent with the overall treatment standards outlined in 107.07-08.A. Family Centered Practice.

Response: The Department thanks the commenter for this comment. The Treatment Planning Team as described in 107.07-04.E is intended to describe the team of professionals required by federal regulation 42 C.F.R. §441.156(d) to participate in the planning process. As stated in policy 107.07-04, the member's parent or guardian, when applicable, must be involved in the planning and treatment process. The Department intends that families remain involved in a robust manner in an ongoing basis. No changes made to final rule.

26. Section 107.07-07.B.j As pointed out in section 107.07-0.E.1, when the resident is a minor the parent or guardian should be a named team member.

Response: Please see the Department's response to comment 25.

27. Section 107.07-07.B.1.l.vii Treatment plans should contain a transition discharge plan and they should require that a care coordinator assists successful transfers home. It is insufficient that a list of resources be provided to parents, guardians, and natural supports. A treatment plan that clearly explains *how* to obtain said resources and/or care coordination services should be provided to ensure referrals are made effectively and efficiently to decrease the chance of re-admission in to the facility and increase the success of the client.

Response: The Department thanks the commenter for this comment. The Department agrees that the PRTF should have a more active role in a member's discharge and transition from the program. The Department has added language to the responsibility of the Clinical Coordinator in 107.07-03.C for the final rule as follows:

"Additionally, the Clinical Coordinator must serve on the member's team to develop the ITP and must facilitate the member's discharge and transition to aid in assuring a successful transition from the PRTF.

28. Section 107.07.B.2.c Please add an additional clause that requires that the treatment plan must be reviewed after every third incident of physical restraint, isolation, or seclusion. Uses of such emergency intervention indicates a possible treatment plan failure indicating the reasonableness of plan review. Consider language such as "After the third incident of physical restraint, mechanical restraint, chemical restraint, isolation, or seclusion the treatment plan will be reviewed by the treatment team to discuss the incidents and consider the need to conduct a Functional Behavior Assessment and or amend the existing treatment plan."

Response: The Department agrees and believes that the rules require that staff involved in a behavioral incident review the adequacy of the treatment plan interventions employed during the debriefing process and consider alternative interventions to prevent future occurrences after each incident. No changes made as a result of this comment.

29. 107.08-01.A The MDDC believes that restraint and seclusion indicates a treatment failure and should only be used as the last resort. Please amend 107.08-01.A to say "When the <u>emergency</u> intervention is necessary to protect the member from causing harm to self or others and<u>, only after other less intrusive interventions have failed or been deemed inappropriate.</u> ~~to prevent further serious disruption that significantly interferes with others' treatment.~~ Restraint or seclusion must not be utilized solely to address the comfort, convenience, or anxiety of staff, or as a form of coercion, discipline, or retaliation;"

Response: The Department thanks the commenter for this comment. The Department feels that the suggested edit to 107.08-01.A is unnecessary. The Department has agreed that restraint and seclusion shall be necessary only when it is necessary to protect the member from causing harm to self or other, and 017.08-01.A has been updated to reflect that change. The recommended edit focusing on using the interventions only when others have failed or been deemed inappropriate it already in policy in 107.08-01.B; "The intervention is the least restrictive emergency safety intervention necessary to resolve the emergency situation after other methods have been proven ineffective or inappropriate." The Department interprets "proven ineffective" as analogous to the interventions having failed, thus the suggested edit is redundant and not required at this time. No changes made as a result of this comment.

30. 107.08-02.D.2 Please reconsider the time limit of maximum restraint and seclusion length in an order. 4 hours for members 18-21, 2 hours for members ages 9-17, or 1 hour for members up to age 9 is too long. Certainly, if the guidance for general timeout is the same number of minutes as one's age it should be similar if not less duration during the more traumatic restraint or seclusion intervention. Orders should be as short as possible and the rule should protect people from the potential trauma of being placed into an unduly long restraint or being witness to a resident enduring said restraint.

Response: The Department thanks the commenter for this comment. The standard referenced is intended to provide the outer limits of the use of restraint and seclusion as allowable by Federal regulation 42 C.F.R. §483.358(e)(2). Additionally, the Department reviewed Federal regulation against the Rights of Recipients of Mental Health Services who are Children in Need of Service, and chose the most strict standard for this policy. Per policy section 107.09-02(E)(1), the restraint or seclusion must be limited to no longer than the duration of the emergency safety situation. Additionally, in 107.09-04(A), the team physician or nurse practitioner must conduct a face-to-face assessment of the member within one (1) hour of the initiation of the intervention to assess their physical and psychological well-being. The standards are safeguards against continuing a restraint or seclusion longer than medically necessary to resolve the emergency safety situation. No changes were made as a result of this comment.

31. 107.08-02.F Thank you for banning prone restraints. Restraint position asphyxia, which can lead to death, is a real concern for all restraints and can happen in any restraint which hinders chest and abdomen movement. In additional to banning prone restraints please consider adding language that bans any restraint in which hinders chest and abdomen movement which can result into restraint-related positional asphyxia.

Response: The Department thanks the commenter for this comment. The Department agrees that it is paramount that providers practice and promote member safety and comfort when places into a restraint. The following language has been added to 107.09-02(G) in the final rule:

"Additionally, providers must not initiate or sustain any restraint that may hinder chest and abdomen movement."

32. 107.08-03.A.1. It is not enough for clinical staff to be monitoring while any staff actually does the physical restraint. Please amend language that only trained staff is permitted to use physical restraints.

Response: The Department thanks the commenter for the comment. The Department agrees and has added the language in 107.09-01(C) that only a staff with specific training in restraints and seclusion may perform these interventions for the final rule.

33. 107.08-07 Thank you for specifying that the member's parents or legal guardians must be given the opportunity to participate in the discussion.

Response: The Department thanks the commenter for this comment and appreciates the support on this decision.

Commenter 4:

34. Commenter 4 stated that she is a parent of a 23 year old young man on the autism spectrum. The commenter shared her personal experience of raising her son with behavioral issues, and spoke particularly of inpatient stays at Spring Harbor Hospital. The commenter shared that many challenging behaviors from individuals with developmental disabilities are actually related to pain. In our son's case, we have since begun to understand that headaches, constipation and tooth pain can cause him to act out in ways that may appear to be psychiatric in nature. The commenter believes that proper medical evaluations and attention could have prevented the extended stay at SHH.

Response: The Department thanks the commenter for this comment. Please see the response to comment 24.

35. Because of the lack of community supports in Maine, when my son became injurious to himself, we had no other option but hospitalization at SHH. If there had been some sort of net, i.e.: crisis supports with trained personnel, we could have kept our son at home and worked with his existing primary care and specialists to evaluate for medical issues. It was far more costly to be admitted into such a unit than it would have been to offer additional, qualified in-home supports.

Response: The Department thanks the commenter for this comment. The Department agrees with the commenter that residential or inpatient care should only be provided when community-based options are insufficient to meet the member's needs. The Department understands there are concerns regarding the adequacy regarding the community-based system; however, there is also a need for the PRTF level of care. The Department does not discount needs for community-based services. This rulemaking is designed to add an inpatient treatment option for individuals with serious mental illness. No changes were made as a result of this comment.

36. Psychiatric care in the absence of a thorough medical evaluation will only extend a patient/client's stay in that facility. A thorough medical assessment (ruling out things such as seizures, constipation, headaches, tooth pain, gynecological issues, allergies and medication side effects or interactions) must go beyond checking blood pressure, looking at ears, eyes and throat and measuring height and weight— which is what my son experienced upon admittance to SHH.

Response: The Department thanks the commenter for this comment. Please see the response to comment 24.

37. Historically, the use of restraints and seclusions have been a cornerstone "treatment" in psychiatric facilities. My son was not being restrained at home or at school, but was initiated into that practice within his first week at SHH. It is well known that the use of restraint and seclusion actually leads to a higher "need" to restrain and seclude, and that is what my son experienced. Because R&S is an acceptable intervention in psychiatric facility, it was used in excess and in the absence of other more effective practices, resulting, eventually, in injury and surgery, not to mention trauma.

Response: The Department understands that restraint and seclusion are serious interventions and as such should only be administered in certain situations. The Department has created a variety of safeguards in this policy to prevent over-use of restraint and seclusion, including but not limited to prohibiting a standing order for restraint and seclusion. Restraints and seclusions must be ordered by the medical director during the emergency safety situation. Each restraint and seclusion must be followed by physical and psychological examinations, staff debriefing, and a review of the situation and interventions employed in an effort to prevent future occurrences. The Department would also like to reiterate that members with a primary autism diagnosis are not eligible to receive this service. No changes were made as a result of this comment.

38. Unfortunately, because of the "history of restraint and seclusion" that became a part of my son's medical record at SHH, in-home support agencies as well as residential treatment facilities in Maine were unable to accept him as a client. We were told that our son needed to exhibit a certain number of weeks without restraint before they could be comfortable transitioning him into their services. However, because the use of R&S is such a common tool, it was impossible for the staff on the SHH unit to properly introduce other models of behavior supports, preventing a timely discharge. Basically, he was stuck in SHH because of their use of R&S that was impossible to reverse.

Response: The Department thanks the commenter for this comment. The Department's hope is that the heightened scrutiny surrounding restraint and seclusion in this policy will prevent historical over-use of these intrusive interventions. The Department understands the commenter's situation was frustrating and it is not the Department's intent to create these types of barriers to services. No changes were made as a result of this comment.

39. The commenter offered that thorough medical evaluations must be in place to rule out treatable medical conditions, injury or drug interactions.

Response: The Department thanks the commenter for this comment. Please see the response to comment 24.

40. Additionally, the commenter stated that funding PTRFs without also growing community supports will lead to clients who are unable to transition out of psychiatric facilities.

Response: The Department understands and appreciates the commenter's concerns on community-based treatment options available within the state. The Department does not believe that offering the PRTF service within the state of Maine is mutually exclusive activity from continuing efforts to improve the community-based services system in Maine. The Department believes that a secure treatment option is a crucial benefit for children who cannot be served in other settings. No changes were made as a result of this comment.

41. The use of restraints and seclusions is known to lead to trauma, injury and an irreversible reliance of continued use of restraint and seclusion.

Response: The Department thanks the commenter for this comment. Please see the response to comment 38.

42. It is my understanding that the state does not receive or evaluate restraint and seclusion data from Spring Harbor Hospital and therefore, severely disabled individuals like my son, are experiencing a lack of advocacy on their behalf regarding physical and chemical restraints. Without proper oversight in place, I believe it is irresponsible for the State of Maine to open additional facilities that will also be unmonitored in the same way.

Response: The Department thanks the commenter for this comment. The Department appreciates the commenter's concern on restraint and seclusion in hospital-based settings. Hospital settings are subject to the Medicare Conditions of Participation, and a sample of restraints is evaluated in accordance with these conditions. With regard to PRTFs, each occurrence of restraint and seclusion is reportable to both the Office of Child and Family Services as a reportable event and must be reported to the parent or guardian. Additionally each occurrence is reviewed with the member and within the treatment team after each occurrence. No changes were made as a result of this comment.

Commenter 5:

43. Commenter 5 stated that research shows that youth experience similar or better outcomes with community-based services at less cost to the taxpayer. The commenter discussed an evaluation of a five-year program in which nine states provided home and community-based services as alternatives to PRTFs found that these services allowed youth to maintain or improve functioning with community or home-based services at less cost than institutional services. Child welfare advocates recommend avoiding out of home placement for children, especially teenagers. Community or home-based services have also been found to yield similar or improved outcomes for youth at less cost in similar studies of substance abuse treatment and youth justice intervention.

Response: The Department understands and appreciates the commenter's concerns on community-based treatment options available within the state. The PRTF is an additional level of care not currently available in the State of Maine and is not intended to be a replacement for community-based services. The Department does not believe that offering the PRTF service within the state of Maine is mutually exclusive activity from continuing efforts to improve the community-based services system in Maine. The Department believes that a secure treatment option is a crucial benefit for children who cannot be served in other settings. No changes were made as a result of this comment.

44. The commenter stated that "experts and practitioners from across the state have recommended a statewide assessment to provide an understanding of how the system is currently servicing its youth, and what assets and resources currently and potentially exist to serve youth in ways that result in the best possible outcomes and are the most cost effective". Though high-quality secure care is a component of a continuum of care, research shows that there are other services along the continuum that have been found to be effective that are not widely utilized in this state. There are also currently out of home treatment facilities being utilized in the state of Maine for which outcomes are unknown. There is a lack of data on what home based and community-based services are available, and what home based and community-based services are needed. A system wide assessment as well as a mapping of assets in communities across the state would provide data that is currently missing but needed to make decisions related to serving youth in the state of Maine. There are also other best practices, including involving directly impacted youth in every stage of developing and evaluating any interventions that serve youth.

Response: The Department thanks the commenter for this feedback and will take it under consideration.

Commenter 6:

45. Commenter 6 explained that NAMI Maine is generally supportive of this level of care to defer youth struggling with a mental health condition from being adjudicated delinquent and placed in Long Creek as a means of accessing mental health treatment. The commenter stated that the juvenile justice system is charged with rehabilitating problematic behaviors, not the treatment of

mental illness, and by placing youth in a correctional facility due to mental health needs, Maine is effectively criminalizing mental illness. The commenter stated that Maine does not have a residential mental health care facility that can treat youth in a locked facility, while still delivering care focused on recovery, not behavior management. Their hope is that by creating this level of care, Maine can help keep youth out of the criminal justice system.

Response: The Department thanks the commenter for this comment and appreciates the support in the development of this level of care.

46. The commenter opined on the state's mental health system as a whole and suggested Maine can do better in a number of areas in building a sustainable system of care.

Response: The Department thanks the commenter for this comment. No changes were made as a result of this comment.

47. The commenter believes a section should be added to 107.04-02.A.1 to include a family or youth mental health advocate.

Response: The Department appreciated the comment; however we do not believe it is appropriate to include an advocate as a required member of the Clinical Certification of Need Team in all cases. The role of the CCON Team is to determine eligibility for the PRTF service. The member's parent/guardian may request advocate involvement at any time. No changes were made as a result of this comment.

48. This level of care should be seen as short term, therefore, the certification requirements should be amended to require reassessments within 6 months. Providers should be expected to deliver a standard of care in which youth are released from the facility within 4 to 5 months. A reevaluation at 6 months will determine and advise what approaches need to be altered to better support the individual. To avoid any ethical conflict, the licensed mental health professional carrying out the reassessment should not be employed by the provider. NAMI Maine does not support a child being placed in a secure facility any longer than one year. A time limit for length of stay should be outlined in this rule in order to ensure individuals do not stay in the facility for years.

Response: The Department thanks the commenter for this comment. The CCON process requires a re-evaluation of need every sixty (60) days which is more stringent than the suggested six months by this comment. The Department declines to place a maximum length of stay on this service as service caps for children are generally disallowed by the Centers for Medicare and Medicaid Services. No changes were made as a result of this comment.

49. Section 107.05 focuses on the services that are to be provided, however, those services only focus on the medical model. Mental wellness is achieved only through a combination of medical and alternative approaches. As such, 107.05-03 must include:

- Youth Peer Support
- Psychosocial Educational Curriculum
- Yoga and Meditation Courses
- Cooking classes focused on including vegetables into diet

Response: The Department thanks the commenter for this comment. The Department does not believe it is appropriate to provide peer support services within the setting of a locked psychiatric facility. We believe this could present significant safety concerns for the member and the peer support as well. With regards to

psychosocial educational curriculum, the required individual and group therapies will serve this need. Yoga, meditation, and cooking classes are not Medicaid reimbursable services; however this does not preclude a PRTF from providing this service on a voluntary basis. No changes were made as a result of this comment.

50. 107.05-03.F states, the provider is required only to provide BCBA consultation with prior authorization. This level of care should be expected to provide evidence-based care for every service they provide. As such, the regulations should state: 'Board Certified Behavior Analyst services as determined beneficial to the child."

Response: Medicaid rules requires that all services delivered must be medically necessary rather than simply beneficial to the member. 107.05-03 states, "When medically necessary, PRTFs must assure the provision of ancillary services to members enrolled in the PRTF." The Department believes this language is sufficient to allow the provision of BCBA services when medically necessary.

51. 107.07-03 should require that the Medical Director be a board-eligible or board-certified child and adolescent psychiatrist. 107.07-03.A.2 can be omitted. The Administrator position should have a Master's Degree in social work, public administration or public health from an accredited school and five years program administration experience. The Clinical Coordinator must be a LCSW or LCPC with at least 5 years of experience in the diagnosis and treatment of children with serious behavioral health conditions. There must be high standards for the leadership of these programs. This level of care provides the opportunity to deliver a comprehensive package of proven approaches for youth struggling with on-going and serious mental health needs. It is critical for highly qualified professionals to provide services at this facility. They must have knowledge of youth mental health and be equipped with the skills necessary to best support youth.

Response: The Department thanks the commenter for the comment. Please see the response to comment 13 regarding medical director requirements. Additionally. the Department believes the Administrator position does not require Master level education to perform the duties outlined in this rule. With regards to the clinical Coordinator position, the Department believes that two years of experience is sufficient for this role. The Department agrees that ideally these roles would be filled by individuals with high levels of experience. In drafting these rules, the Department sought to strike a balance between high levels of education and experience for staff and realistic expectations for filling staff roles. No changes made as a result of this comment.

52. Section 107.07-09.D should read: "First aid certification and Youth Mental Health First Aid certification is required. Certification must be reviewed on an annual basis." Mental health first aid is critical for Psychiatric Residential Treatment Facilities. Children requiring this level of care will all have histories of significant trauma, as Maine has higher levels of childhood trauma than the national average. It is pertinent that facilities be required to operate a trauma responsive agency using an evidence-based or proven national model.

Response: The Department thanks the commenter for this comment. The intent of requiring first aid training is to assure all staff may assist when a medical intervention is required. First aid training is required on an annual basis. The Department believes that through the BHP's training, years of experience, and clinical supervision they would be well prepared to support a member with a trauma history. The Department is also hesitant to require a specific training on youth mental health as this training is not currently available in Maine. No changes were made as a result of this comment.

53. The use of restraint is a treatment failure. Programs should be required to respond with immediate corrective action to every episode where seclusion or restraint has occurred, as evidence of a team failure. Staff should understand that the use of restraints will likely result in additional trauma for youth. Seclusion and restraint should never be part of an individual's plan. The only time a child should be secluded or restrained is if it is for the immediate safety of an individual. All staff should have extensive training in de-escalation with the clear expectation that every effort must be made to de-escalate a situation.

Response: The Department thanks the commenter for this comment. Please see the responses to comments 37 and 38. No changes made as a result of this comment.

54. 107.08-02.F should read: "Under no circumstance may prone restraints, chemical restraints, or mechanical restrains be ordered or used." These forms of restraint are inhumane and unethical. 107.08-02.D.2 should be edited to include different time limits related for the use of seclusion and restraint. The timelines provided are completely unacceptable for use of restraint. The following edits should be made: "Under no circumstances may any a restraint occur for more than 8 minutes for members ages 18-21 ; 5 minutes for members ages 9-17; or 2 minutes for members up to age 9." There is absolutely no reason for an individual to be restrained or secluded for hours.

Response: The Department has already prohibited prone restraints in this policy. Additionally, as a response to comment, the Department is further restricting restraints that may hinder chest or abdomen movement. With regards to mechanical and chemical restraints, the Department believes that the PRTF must have the ability to utilize mechanical and chemical restraints when less intrusive interventions were insufficient to adequately protect the member. The Department believes there are sufficient safeguards in place within Federal regulation regarding the use of mechanical and chemical restraint including the process by which these restraints may be ordered. Each member has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation, as supported in 42 CFR 483.356(a)(1).

The Department would like to refer the commenter to its response to comment 30. The Department has implemented maximum amounts of time for restraint or seclusion that are more stringent than required within the Rights of Recipients of Mental Health Services who are Children in Need of Services. The time-frames in the rule correspond with those established in federal regulation specific to PRTF in § 483 subpart G.

55. We hope the department will closely track the outcomes of youth placed in this level of care and hold providers to a much higher degree of accountability for helping youth recover from their illness. High school completion rates should be tracked as an indicator of program success.

Response: The Department does intend to closely monitor this service as it develops within the state. The Department can monitor health outcomes based on MaineCare claims data. The Department does not have access to educational records or other detailed data sets. The Department would like to reiterate that PRTFs are not intended to be long-term placements for members. No changes were made as a result of this comment.

56. The development of this level of care does not address the current lack of a children's behavioral health system. Nor does it address Maine's failure to embrace evidence-based practice and true performance based standards for providers. There must be an accessible continuum of mental health services from early intervention to community-based services that focus on the mental wellness of Maine's children. Investing more funds into the current system does not hold the answers for a

brighter tomorrow; rather we must build a new system that invests in a solid structure to support the development of our children into mentally well adults.

Response: The Department understands and appreciates the commenter's concerns on the availability of service options within the state. The Department does not believe that offering the PRTF service within the state of Maine is mutually exclusive activity from continuing efforts to improve the community-based services system in Maine. The Department believes that a secure treatment option is a crucial benefit for children who cannot be served in other settings. No changes were made as a result of this comment.

Commenter 7:

57. Commenter 7 stated that experts in the juvenile justice field in Maine have stated that a system-wide assessment must be done by the Department to assess current gaps in the system, and stated the assessment has not been done prior to this rulemaking. The commenter feels the proposed rule is "premature" and "ought not to be made." The commenter also feels that the proposed rule does not adequately address the overuse of law enforcement to address mental health-related behaviors.

Response: The Department thanks the commenter for this comment. The Department held a public forum in February of 2018 to gather input from stakeholder in the development of this rule, and incorporated feedback received during the forum into the draft rule. The Department also held a public hearing as a part of this rulemaking, and gathered written comments. The Department does understand that a systematic assessment of the state's child behavioral health system has not been completed for many years, and will take this under advisement. No changes were made as a result of this comment.

58. The commenter opined that the Department has not shown that PRTFs are necessary or wise investments, and criticized the Department on opening another CMS certified program when the Department has been unable to reinstate the Riverview Psychiatric Center. The commenter instead suggested the system-wide assessment and to bolster community-based services as less costly alternatives to institutionalization.

Response: The Department understands and appreciates the commenter's concerns on community-based treatment options available within the state. The Department does not believe that offering the PRTF service within the state of Maine is mutually exclusive activity from continuing efforts to improve the community-based services system in Maine. The Department believes that a secure treatment option is a crucial benefit for children who cannot be served in other settings. No changes were made as a result of this comment.

59. The proposed rule does not Sufficiently Address the Criminalization of Mental Health That Is Already a Problem in Maine Residential Treatment Facilities. The commenter discussed Maine's history of "rampant, inappropriate use" of law enforcement to address mental illness on behalf of residential facilities. The commenter suggested the Department should use its licensing rules to specify the types of incidents that could be appropriate for law enforcement intervention. The commenter stated that the Department should state a preference for crisis services or other alternatives to law enforcement, and state within the PRTF policy that the facility should review calls to law enforcement to identify trends and trouble-shoot to avoid making calls in the future.

Response: The Department agrees with the commenter on the severity of utilizing law enforcement, and within policy has restricted accessing law enforcement to only when ordered by the medical

director. Calls to law enforcement are considered reportable events and must be reported to the Office of Child and Family Services. No changes were made as a result of this comment.

60. The commenter urged the Department to halt its licensing of PRTFs and instead consider funding community-based services that are "more effective in outcome and cost." The commenter then stated that to do this, the Department must conduct a system-wide assessment of the children's mental and behavioral health resources in Maine.

Response: The Department understands and appreciates the commenter's concerns on community-based treatment options available within the state. The Department does not believe that offering the PRTF service within the state of Maine is mutually exclusive activity from continuing efforts to improve the community-based services system in Maine. The Department believes that a secure treatment option is a crucial benefit for children who cannot be served in other settings. No changes were made as a result of this comment.

Commenter 8:
The commenter has supplied several recommendations about the PRTF regulation and also included some general comments on the use of PRTF services for children in Maine.

61. There is no definition of "positive supports", "positive support strategies", or "positive behavior support strategies". The commenter urged the Department to review an example of a definition of "positive supports strategies" used in state regulations from the State of Minnesota's Positive Supports Rule 9544. There "positive support strategy" is defined as "a strengths-based strategy based on individualized assessment that emphasizes teaching a person productive and self-determined skills or alternate strategies and behaviors without the use of restrictive Interventions."

Response: The Department thanks the commenter for this comment and has adopted the definition as suggested within the final rule.

62. 107.07-07(B)(1)(e). The commenter strongly supports the requirement here that the treatment plan "be designed to achieve the beneficiary's discharge from impatient status at the earliest possible time".

Response: The Department thanks the commenter for this comment and appreciates the support.

63. Please add Section 107.07-07.B.1.l.viii requiring that discharge plans "Include a care coordinator to ensure successful home, community, and medical transition."

Response: The Department thanks the commenter for this comment. Please see the Department's response to comment 27.

64. 107.07-08(A)(4) is grammatically incorrect. Please delete the word "to".

Response: The Department thanks the commenter for this comment and has made the suggested edit in the final rule.

65. 107.07-08(B)(2). This section requires that behavioral plans be monitored, reviewed, and adjusted an ongoing basis based on the child's response to treatment. Please add additional language (which could be inserted as 107.07-08(B)(2)(b)) requiring the treatment planning team to meet after a precise number of incidents of restraint or seclusion in order to consider modifications to the plan. We suggest the following:

"Within 24 hours of a 3rd incident of restraint or seclusion, and after every successive 3rd incident, the Treatment Planning Team must meet in order to consider behavioral, environmental, and other antecedents and contributors to the incidents and to consider modifications to the treatment plan, the potential need for additional functional behavioral assessments, and any other actions designed to minimize the likelihood of further incidents."

Response: The Department thanks the commenter for this comment. Please review the Department's response to comment 28.

66. The term "Treatment Planning Team" is defined, but the rule references the undefined term "Treatment Team." For example, see 107.07-08(A)(4). The term "Treatment Planning Team" should be used consistently. This is especially important because the document indicates that a parent or guardian must include a parent or guardian whenever applicable. A "Treatment Team" might be interpreted as being different from the "Treatment Planning Team" and therefore not required to have the same membership. Please change all instances of "Treatment Team" to "Treatment Planning Team".

Response: The Department thanks the commenter for this comment and has made the suggested edit in the final rule.

67. 107.08-01(A). Restraint and seclusion is authorized when "the intervention is necessary to protect the member from causing harm to self or others and to prevent further serious disruption that significantly interferes with others' treatment." We believe that the clause "significantly interferes with others' treatment" could be interpreted very broadly and used to justify restraint and seclusion that is in fact used to "address the comfort, convenience, or anxiety of staff." We further believe that the offending clause is unnecessary, as actually interfering significantly with others' treatment could constitute harm to others. Accordingly, please amend by ending the sentence immediately after self or others": "the intervention is necessary to protect the member from causing harm to self or others".

Response: The Department agrees with the commenter and has made the suggested edit. The Department believes that the use of "Time Out" will sufficiently address a member's interference with other's treatment. No changes were made as a result of this comment.

68. 107.08-02(D)(2). The proposed rule sets the maximum time for using restraint or seclusion at 4 hours for members 18-21, 2 hours for members ages 9-17, or 1 hour for members up to age 9. This is excessive and puts members at risk for additional trauma. We recommend reducing the maximum limit for 18 to 21 year-olds to 2 hours and to 1 hour for 9-17 year-olds.

Response: The Department thanks the commenter for this comment. Please refer to the Department's response to comment 30.

69. On page 20, the header "107.08 POLICIES AND PROCEDURES (cont.)" should be "107.07 POLICIES AND PROCEDURES (cont.)"

Response: The Department thanks the commenter for this comment. The Department has reviewed the final version of the rule to correct any typos.

70. The commenter expressed concern on the development of a 20 bed PRTF facility due to its high cost, suggesting the per diem rate of 485.72 is "extremely high," and that studies have shown

community based services to be more effective at one-third of the cost. The commenter also stated that the PRTF may have "negative effects on the financial stability of the children's mental health system" resulting in less money available for less-costly alternatives, and the commenter suggested that the high cost of PRTFs would provide financial incentive to maintain individuals at a higher level of care.

Response: The Department thanks the commenter for this comment. In developing the rate for this service, the Department scaled the rates based on the assumption of a 20 bed-facility, but the rule does not dictate any specific facility size or number of beds. The Department believes the PRTF level of care is a necessary addition to the continuum of mental health services in Maine. No changes were made as a result of this comment.

71. The commenter recognizes that there are problems with the current crisis system, that many children are not receiving needed treatment, and that sometimes children are being abandoned in emergency rooms; however, strategies for improving the current system should be explored before investing in a costly highly restrictive alternative with no evidence that such an institution will produce better outcomes for children. The commenter suggested that the Department explore an HCBS children's waiver for psychiatric services, which would, by design and by federal requirements, provide treatment to this population at substantially reduced cost.

Response: The Department thanks the commenter for this response. The Department believes the PRTF level of care is a necessary addition to the continuum of mental health services in Maine. The Department appreciates the concerns regarding the current crisis system. Regarding the suggestion the Department explore an HCBS waiver, the state has researched this option; however, the Department does not believe an HCBS waiver would result in any cost savings or more robust continuum of care. A major challenge to Maine's child mental health system is the dearth of providers both at the paraprofessional and professional levels. Implementation of an HCBS waiver would not ameliorate this situation. It should also be noted that HCBS waivers are subject to caps in terms of the number of members served resulting in waiting lists for services. No changes were made as a result of this comment.

Commenter 9:

72. The commenter opined on their organization' history in the state and suggested that the state is reversing its commitment to home and community based services by proposing to spend more than $3 million to create a PRTF level of care while youth continue to wait for home and community based services. The commenter suggested that without a proposal to increase home and community based services, children will face the same challenges in the current system for youth transitioning home from higher levels of care. The commenter stated that institutionalizing children with behavioral health needs is not the answer to the challenges Maine faces. The commenter continued to state that a study conducted by the U.S. Department of Health and Human Services showed that community-based waiver services are less costly and produced better outcomes than PRTFs.

Response: The Department understands and appreciates the commenter's concerns on community-based treatment options available within the state. The Department does not believe that offering the PRTF service within the state of Maine is mutually exclusive activity from continuing efforts to improve the community-based services system in Maine. The Department believes that a secure treatment option is a crucial benefit for children who cannot be served in other settings. No changes were made as a result of this comment.

73. The commenter also stated that the proposed PRTF goes against 20 years of progress integrating people with disabilities of all ages within their communities and discussed the outcome of *Olmstead v. L.C.*, a 1999 landmark civil rights case, the U.S. Supreme Court said that the unnecessary institutionalization of people with disabilities was discrimination. Specifically, the unnecessary institutionalization of children with behavioral health needs is disability-based discrimination, especially if the institutionalization is due to the failure of the state to provide adequate home and community based services.

Response: The Department thanks the commenter for this comment. The Department believes that PRTFs are a medically necessary component in Maine's continuum of care. Only children who meet the strict criteria established in this policy will be referred to the PRTF. Additionally, PRTFs are intended to be short term placements and not long-term residential options. The Clinical Certification of Need process requires a review of service eligibility and medical necessity every sixty (60) days by design. No changes were made as a result of this comment.

74. The commenter continued that Maine spent $195 million on community based programs for children, then criticized the system as complex and flawed that "has no plan guiding how the money should be spent or ways to measure outcomes." The commenter suggested that DHHS look at the latest research, assess the current children's behavioral health system, and use this information to develop a strategic plan with clear outcome measures and a well-developed quality improvement program before spending more taxpayer dollars.

Response: The Department thanks the commenter for this comment. The Department held a public forum in February of 2018 to gather input from stakeholder in the development of this rule, and incorporated feedback received during the forum into the draft rule. The Department also held a public hearing as a part of this rulemaking, and gathered written comments. The Department does understand that a systematic assessment of the state's child behavioral health system has not been completed for many years, and will take this under advisement. No changes were made as a result of this comment.

75. It is positive that the proposed rules acknowledge that the *Rights of Recipients of Mental Health Services who are Children in Need of Treatment* (RRMHS-C) apply in PRTFs. Further clarification, however, is needed. The RRMHS-C Part B statement of intent states that section III shall only apply in inpatient settings, while treatment planning in residential treatment shall be governed by Part C. The proposed MaineCare rule should be amended to specify that a PRTF is an inpatient psychiatric unit for the purposes of RRMHS-C.

Response: The Department thanks the commenter for this comment and would like to direct the commenter to 107.02-14, definition of Private Psychiatric Treatment Facility, "means a facility other than a hospital that provides psychiatric services to individuals under age 21, in an inpatient setting, and which meets the requirements of this policy." The Department feels this definition is adequate to meet the commenter's request. To be clear a PRTF is distinct from an inpatient psychiatric unit that is part of a hospital. The Department would also refer the commenter to 42 CFR 441.151 which clearly distinguishes between a PRTF and psychiatric hospital. No changes were made as a result of this comment.

76. The Department should use its licensing rules to delineate the limited types of incidents that are appropriate for law enforcement interventions and those that are not. The Department should state a preference for using crisis services or other alternatives to law enforcement. And DHHS should require PRTFs to review calls that they make to law enforcement, in order to identify trends and troubleshoot, so that they can work to decrease rates of future calls to law enforcement.

Response: The Department would like to note that the proposed rule is a part of the MaineCare benefits manual and is separate and distinct from the residential licensing rule. The Department agrees with the commenter on the severity of utilizing law enforcement, and within policy has restricted accessing law enforcement to only when ordered by the medical director. Calls to law enforcement are considered reportable events and must be reported to the Office of Child and Family Services. No changes were made as a result of this comment.

77. 107.02-04: Drug Used as A Restraint (Chemical Restraint): Chemical restraint is defined as a drug administered to "manage a member's behavior in a way that reduces the safety risk to the member or others; has the temporary effect of restricting the member's freedom of movement; is not a standard treatment for the member's medical or psychiatric condition; and can only be administered by an appropriately licensed staff member…" The RRMHS-C Part B, IV, E addresses "involuntary emergency treatment," otherwise known as chemical restraint. This more narrowly defines an emergency as a "situation in which, as a result of a recipient's behavior due to mental illness there exists an imminent danger of bodily injury to the recipient or to others." There are also many more procedural protections for children, including a determination that there is a "recognized form of treatment," "no one legally entitled to consent," and that a "reasonable person concerned for the physical safety of the recipient or others would consent under the circumstances." The RRMHS-C approach illustrated here should be adopted in the proposed MaineCare rule and should replace the definition of chemical restraint that is in the current proposed version.

Response: The Department thanks the commenter for this comment. The Department agrees with the Commenter and chemical restraints are not permitted in the final rule. The Department has removed the definition of "Drug Used as a Restraint" from the final version of policy and has replaced it with a section discussing Medication Pro Re Nata (PRN) and its use within a PRTF. Additionally, the Department would like to note that it has amended policy 107.09-01(A) to remove "and to prevent further serious disruption that significantly interferes with others' treatment" to more clearly relate the use of restraint or seclusion to bodily harm of self or others.

78. 107.02-13(H): Alleged Abuse by a Non-Professional Caregiver: A reportable event includes alleged abuse by a Non-Professional Caregiver. It is not clear whether that would include a parent.

Response: The Department thanks the commenter for this comment. This language is consistent with the reportable events process A non-professional caregiver may include the parent/guardian. No changes were made as a result of this comment. Of note, in response to a previous comment the Department has added a definition of "caregiver" to provide additional clarity.

79. 107.02-14: Restraint: The rules define "restraint" as a "personal restraint, mechanical restraint, or drug used as a restraint." Combining these three, distinct types of restraints into one intervention is troublesome, particularly because of the conflict it creates with the differing requirements in the RRMHS-C. The RRMHS-C has different standards and requirements before the use of each type of restraint. Furthermore, the RRMHS-C requires that restraints may only be used when absolutely necessary to protect against serious physical injury to self or others. It also requires that a less restrictive measure first be attempted and be proven inappropriate or ineffective. This is not articulated in the proposed PRTF rules, and the proposed rules should be revised to be compliant with the stricter standard of the RRMHS-C.

Response: The Department thanks the commenter for this comment. The commenter's suggestions already exist in the proposed policy. 107.08-01 details the conditions under which a restraint or seclusion may be utilized. 107.08-01.C contains language assuring the intervention is the "least

restrictive emergency safety intervention necessary to resolve the emergency situation after other methods have been proven ineffective or inappropriate." The Federal government via 42 CFR 483 subpart G details standards on restraint and seclusion which providers must attest to in order to be Federally certified as a PRTF. Additionally, the Department reviewed 42 CFR 483 subpart G against the Rights of Recipients document and chose the stricter standards for the proposed policy. No changes made as a result of this rulemaking.

80. 107.02-16: Serious Injury: The definition of Serious Injury does not include the death of a member or resident, as required by 42 C.F.R. §483.374(b).

Response: The Department thanks the commenter for this comment. Serious Injury is a term used by the Department via its "Reportable Events" process to determine what types of injuries would be included under that designation and to direct reporting as shown in Appendix C. This is not a term defined or governed by the Federal government. 42 C.F.R. §483.374(b) speaks to "Serious Occurrence" which does include death of a member as the commenter states, and subsequently is defined in policy under 107.02-18, which is consistent with the CFR. No changes were made as a result of this comment.

81. 107.03: Introduction: The third paragraph provides that individuals with intellectual disabilities and Autism are protected by 34-B M.R.S.A. §5605. DHHS should elaborate further because this is not clear. Under 34-B M.R.S.A. §5605h, children with intellectual disabilities and autism admitted to PRTFs would need behavior management plans pursuant to 34-B M.R.S.A. §5605(13). Further, those behavior management plans must be developed according to the statutory process, including having DRM (as the advocacy agency referred to in Title 34-B) involved in the development of those behavior plans.

Response: The Department thanks the commenter for this comment. The commenter is correct that Title 34-B directs behavioral management plans which much be developed according to statutory process. The intent of including the statement for this population and 34-B was to remind providers of their obligation to adhere to statute when serving an eligible member who may additionally have an intellectual disability or autism. The Department feels that this reminder in coordination with the Behavior Management Standards in 107.07-08(B) sufficiently provide the framework for providers to serve members who may have these needs. No changes were made as a result of this comment.

82. The fourth paragraph specifies that in order to qualify for PRTF services, all other community resources for the member must have been determined to be inadequate to meet the member's need. In many instances, children will be determined qualified for PRTF services because the Maine Department of Health and Human Services (DHHS) has not provided adequate community services. For example, many children are on waiting lists for services under Section 28 and/or Section 65 and have been waiting for more than 6 months. If DHHS provided services or arranged for the provision of them, many children would not qualify for PRTF services. Children with behavioral health needs should not be subject to a restrictive inpatient setting, such as a PRTF, because DHHS has not provided adequate home and community based services. This rule should require the documentation of full provision and failure of home and community-based services – or the acquisition of a waiver from DHHS – prior to a determination of inadequacy of these less restrictive services and admission to a PRTF.

Response: As noted in previous responses to comments, the Department believes the PRTF is an important component within the continuum of services for children with mental health needs. While robust community services are also an important part within the continuum of care, the need for PRTF exists regardless of the availability of community-based services. The Department would

also like to note that MaineCare does not directly provide mental health services. Rather, MaineCare provides reimbursement for mental health services delivered by any willing and qualified provider.

83. 107.04-02(A)(1)(c): Clinical Certification of Need (CCON) for PRTF Services – Team: This provision should clarify that a parent or child can request that an advocate or other individuals can participate as a member of the CCON team.

Response: The Department thanks the commenter for this comment. Please see the Department's response to comment 47.

84. 107.04-02(B)(1)(b): Community-Based Resources Available in the Community do not Meet the Needs of the Member: The rule requires certification that community resources do not meet the treatment needs of the member. This provision does not take into account the reason for the lack of adequate community resources. If the lack of community resources is because DHHS has not done what it can to ensure that the member has adequate community resources, then DHHS should be required to provide adequate home and community based resources before placing the child in a PRTF.

Response: The Department thanks the commenter for this comment. Please see response to comment 82. No changes made as a result of this comment.

85. 107.05-04: Discharge Planning: Sub paragraphs (C) & (D) ensure that members have a 7-day supply of medications when discharged and that a prescribing provider has been identified and a visit is scheduled. However, that does not go far enough. This presumes that a visit with a prescribing provider can be scheduled within 7 days. Some providers have months-long waiting lists or are not taking new cases, particularly in remote areas of the state. Sometimes members are not able to keep the original appointment, even if scheduled within 7 days. There needs to be flexibility to allow members access to medications until a visit with a prescribing provider occurs, when the visit does not take place within 7 days of the date of discharge.

Response: The Department thanks the commenter for this comment. The Department has amended the final rule to allow for a 30-day supply of medications unless a 30-day supply is contrary to prescribing guidelines, if the members insurer will not reimburse for a 30-day supply, or if the member's prescriber determines that a 30-day supply is medically contraindicated.

86. The discharge planning process laid out in the proposed rule also does not go far enough. As it is currently written, no care coordinator or case manager will be assigned to the member. There is nothing ensuring that before a member is discharged a plan is in place, with home and community based providers identified, along with adequate staffing when discharged and beyond. DHHS must do more to ensure that upon discharge from the PRTF, an appropriate plan is put in place that will meet the member's clinical needs in the discharge placement. The focus should be on keeping the individual in the community and preventing readmission to the PRTF and future hospitalization or incarceration.

Response: The Department thanks the commenter for this comment. The Department has added care coordination to the clinical coordinator role in order to aid in transitions. The Department understand the need for robust discharge planning and adequate eservices upon discharge; however, the Department cannot guarantee that a member will received any specified MaineCare services. Members may access case management via Targeted Case Management or Behavioral Health Homes to also aid in transitioning back to the community. No changes made to the final rule.

87. 107.07.06: Disclosures: PRTFs should be required to advise families and members of their rights under the *Rights of Recipients of Mental Health Services who are Children in Need of Treatment* and provide families and members with a copy of the publication, receipt of which should be acknowledged in writing at the time of the admission.

Response: The Department agrees and has added this requirement to the final rule.

88. 107.07-06(A)(3): Emergency Restraint and Seclusion: This provision requires PRTFs to obtain, in writing, an acknowledgement that the member, family or guardian has been informed of the facility's restraint and seclusion policy. However, sub paragraph 4 requires the facility to provide the member, family or guardian with a copy of the facility's restraint and seclusion policy, but does not require that facility to obtain a written acknowledgement that they have received a copy of the policy. If there must be a written acknowledgement of being advised of the policy, there also should be a written acknowledgement that they received a copy of the policy.

Response: The Department thanks the commenter for this comment. The Department agrees and has amended 107.07-06(A)(3) to the following:

"Obtain an acknowledgement, in writing, from the member, or in the case of a minor, from the parent or legal guardian that he or she (or they) have been informed of and have received the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgement in the member's record;"

89. 107.07-07(B)(1)(l): Discharge Plan: This provision requires that the treatment plan includes a discharge plan. The discharge plan must contain a list of resources tailored to the member's individualized needs and the situation of the family to increase the likelihood of a successful and sustainable discharge. The PRTF should be required to assist families with identifying and accessing home and community based services. A successful and sustainable discharge is essential to the member's success. Discharging members without adequate home and community based services in place is the opposite of a successful and sustainable discharge plan.

Response: The Department thanks the commenter for this comment. The Department would like to refer the commenter to is response to comment 28.

90. 107.07-08(A): Additional Treatment Standards: Family Centered Practice: This provision requires that the PRTFs be full partners with the parents in all aspects of the child's treatment. This section is welcome. However, Early Periodic Screening Diagnostic and Treatment ("EPSDT") requires that parents and families be offered assistance with transportation and scheduling of appointments. 42 C.F.R. §441.62. See also 42 C.F.R. §421.63. In order for families to be full partners, they will need to attend meetings at the facility and regularly visit with the member. Parents and families may live far away from the facility (or facilities) and, given Maine's geography, may need assistance with transportation to get to the facility. The Sec. 113 Non-Emergency Transportation (NET) Waiver is inadequate. DRM is aware of numerous complaints about the NET system and difficulties users have in utilizing the system and making complaints about the system. There is also a question as to whether visits by families will be covered, as the covered member is at the facility. DHHS needs to ensure that assistance with transportation is available as well as assistance in scheduling appointments for services.

Response: The Department has received clear direction from CMS that unloaded miles (trips in which the member is not in the vehicle) are not considered to be Medicaid Services and are non-coverable.

The Department cannot provide NET Transportation for parents to visit members receiving PRTF services. However, the Department recognizes this limitation and would like to note that telemedicine may be utilized to engage parents/guardian and families in PRTF services. No changes were made as a result of this comment.

91. 107.08-01: Restraint and Seclusion: General Requirements: Based on the definition of restraint this section lumps together the use of physical restraint, chemical restraint, mechanical restraint, and seclusion, and allows for their use "when the intervention is necessary to protect the member from causing harm to self or others and to prevent further serious disruption that significantly interferes with others' treatment." This contradicts the RRMHS-C, which only permits the use of seclusion "to prevent further serious disruption that significantly interferes with other recipients' treatment." This standard cannot apply to the use of restraints, including chemical and mechanical restraints. Furthermore, the RRMHS-C only permits the use of restraint "when absolutely necessary to protect the recipient from serious physical injury to self or others." The RRMHS-C likewise only allows the use of Involuntary Emergency Treatment (which includes chemical restraint or involuntary medication)—RRMHS-C allows this only when "as a result of a recipient's behavior due to mental illness there exists an imminent danger of bodily injury to the recipient or to others." We strongly suggest that the proposed rule clearly identify requirements for the use of physical restraint, chemical restraint, mechanical restraint, and seclusion individually, and ensure these requirements are consistent with the RRMHS-C.

Response: The Department has removed the clause "to prevent further serious disruption that significantly interferes with other' treatment" from the final rule.

92. 107.8-02: Orders for Restraint or Seclusion: Again, we recommend that the rule clearly identify specific requirements for the orders of physical restraint, chemical restraint, mechanical restraint, and seclusion individually, and ensure these requirements are consistent with the RRMHS-C. Additionally, the order should include a description of the less restrictive interventions attempted prior to the use of these severely intrusive emergency interventions.

Response: The Department is choosing to treat physical, mechanical, and chemical restraints similarly, using the strictest criteria present in the Rights of Recipients and 441 CFR 483 subpart G in Federal rule. Nothing in this rule negates the requirements of the rights of recipients. No changes made as a result of this comment.

93. 107.08-05: Use of Time Outs: Paragraph A states that "a member in time out must never be physically prevented from leaving the time out area." The Department should also add language to this to protect children against the use of non-physical coercion.

Response: The Department believes that the term "non-physical coercion" is vague and difficult to enforce. The Department is unclear what the commenter means by this term.

94. Paragraph D(3) states that within one hour of the initiation of the emergency safety intervention, the physician or nurse practitioner must conduct a face to face visit of the member. The RRMHS-C states this face-to-face visit must occur within 30 minutes. The proposed rule must be brought into alignment with the RRMHS-C.

Response: The Department thanks the commenter for this comment and has amended the final rule to state that the face-to-face visit must occur within 30 minutes of the initiation of the emergency safety situation.

95. 107.08 (B) Behavioral Support and Management Standards: We recommend that a child's team meet and review the behavior plan any time a reportable event is filed.

Response: The Department believes that providers must use their clinical discretion when determining the necessity of reviewing the behavior plan, as applicable, following a reportable event. The Department is mindful when drafting policy governing MaineCare benefits that overly-burdensome set of administrative requirements may impede the provider's ability to deliver a quality service. Additionally, it is already the standard that the plan is reviewed after every occurrence of restraint or seclusion. No changes made as a result of this comment.

96. 107.07-10(A)(1)(d): Reporting Requirements: State Advocacy Agency: This provision requires PRTFs to report Serious Occurrences to the Department's State Advocacy Agency. No such entity exists. Federal regulations require PRTFs to document reporting Serious Occurrences to the state protection and advocacy agency (P&A). 42 C.F.R. §483.374(b). That documentation also must include the name of the person at the P&A to whom the occurrence was reported. 42 C.F.R. §483.374(b)(3). As noted previously, federal regulations define the death of a member as a serious occurrence that must be reported to the P&A. 42 C.F.R. §483.374(b).

Response: The Department thanks the commenter for this comment. It is the Department's interpretation that DRM's designation as the State Advocacy and Protection Agency encompasses PRTFs. 5 MRSA §19508 describes the application of the Protection and Advocation designation to residents of children's homes and reads:

This chapter also applies to children with disabilities in children's homes, emergency children's shelters, family foster homes, specialized children's homes and children's residential care facilities, as defined in Title 22, section 8101, and to other residential educational facilities, including the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf and other similar facilities

The proposed licensing rules, filed concurrently with this rule, classify PRTFs as a subtype of Residential Treatment facility. As such, PRTFs fall under the purview of the DRM as the State Advocacy and Protection Agency.

97. 107.08-01(A): Restraint and Seclusion: General Requirements: Harm to Self or Others: This section permits the use of "restraints" and "seclusion" to prevent "further serious disruption." This is very troublesome and is in conflict with the RRMHS-C, which utilizes different standards and requires different practices for the use of physical restraints, chemical restraints, mechanical restraints, and seclusion. See comments above for DRM's comments concerning the proposed rule's treatment of the use of restraint and seclusion.

Response: The Department thanks the commenter for this comment. As previously stated, this language has been removed from the final rule.

98. 108.08-08: Requirements for Third Party Treatment: Consistent with federal regulations, PRTFs must have affiliations or written agreements with hospitals when medically necessary for medical care or acute psychiatric care. According to the Principles of Reimbursement, §21.1, a member must be discharged from the PRTF if the member is hospitalized for more than 4 days. There is no companion federal regulation requiring a discharge after a hospital stay of more than 4 days. Allowing a discharge after a 4 day hospitalization likely will encourage patient dumping. Where clinically appropriate, PRTFs should be required to readmit members who leave the PRTF for medical or psychiatric reasons. According to the Office of MaineCare Services, if an individual in

an adult Private Non-Medical Institution (PNMI) is hospitalized for up to 30 days, the bed is held open and the rate for the other residents can be adjusted upward, so that the PNMI does not lose any money. This should also apply to PRTFs; residents should not be discharged for hospital stays of up to 30 days, and rates should be adjusted for the other members, so that the PNMI does not lose money.

Response: PNMIs are reimbursed differently from PRTFs. Because PNMIs are not considered inpatient facilities, MaineCare cannot reimburse providers for room and board. Instead, room and board for PNMIs is regulated through Section 115, which is entirely state funded. Section 115 does allow for 30 bed hold days, but Section 97 (the MaineCare PNMI rule) does not. The reimbursement PNMIs receive for bed hold days is generally quite minimal. The PRTFs will operate differently. As inpatient facilities, PRTFs are eligible to receive room and board as part of the Medicaid rate. The Department proposes allowing four bed hold days for which the PRTF is eligible to receive the full room and board rate. This is consistent with how the Department reimburses Nursing Facilities.

99. According to §21.2 of the Principles of Reimbursement, therapeutic leave is limited to 7 days per admission. Again, members should be allowed 30 days' medical leave without being discharged. Sections 21.1 and 21.2, when taken together, mean that DHHS policy can permit PRTFs to "cherry pick" members (i.e., admit preferred patients over nonpreferred patients), and discharge those whom they consider troublesome, the same way that children's residential providers can now. This should be unacceptable with residential providers and is unacceptable for PRTFs. PRTFs should not be allowed to discharge a member until the member meets the treatment goals, is no longer eligible for service, or has a legitimate medical emergency lasting longer than 30 days.

Response: The Department thanks the commenter for this comment. The language referenced in §21.2 of the Principles of Reimbursement is consistent with how the Department handles medical leave in a Nursing Facility. Members may be out of a facility for over seven days, but MaineCare may only provide reimbursement for the first seven. The Department understands the commenter's concern, but the Department cannot continue to pay for services that are not being provided. No changes made as a result of this comment.

100. 107.09-01: Waivers: This provision allows DHHS to waive specific PRTF requirements, except that federally mandated requirements may not be waived. There is no time limit on these waivers, no criteria for granting or refusing the waiver, and no review of the grant of a waiver. This is a license for PRTFs to act arbitrarily and capriciously. All that is required is permission from OCFS, and it must be documented in the member's file. There should be more oversight, and notice should be provided to members potentially affected by the waiver request. Members should also receive an opportunity to oppose the waiver request, and notice if the waiver request is either granted or denied.

Response: The Department thanks the commenter for this comment. No federal regulation may be waived, and that is already stated under 107.09-1. The waiver criteria is to allow for providers to waive state developed criteria under certain circumstances, which must be approved by the Office of Child and Family Services, which will have programmatic oversight of the PRTF programs. An example of a waivable requirement could be the requirement for two hours of family therapy weekly in the event the member does not have any family. The waiver criteria is written to allow flexibility and to assure each request is clinically appropriate and approved on an individualized basis. No change was made to the file rule.

101. The commenter stated that there is an "unresolvable procedural deficiency" in the proposed rule, and suggested that DHHS must revise and re-promulgate the rule. The Commenter stated that in

2016, the Subpart D of the federal rules governing PRTFs was amended to add a new section about emergency preparedness. 42 C.F.R. §441.184 requires PRTFs to establish and maintain an emergency preparedness program that meets the requirements of that section. The program must be based on a documented facility based and community risk assessment. It must address resident population, persons at risk, and types of services available in the event of an emergency; include delegations of authority and succession plans; and include an emergency preparedness communications plan that complies with all federal, state and local laws; and it must be reviewed at least annually. It must describe how PRTFs will collaborate with state, local and tribal emergency preparedness officials to maintain an integrated response. DHHS must revise Sec. 107 to add the requirements of 42 C.F.R. §441.184 then reissue notice of Sec. 107, since this provision was missing from the original notice.

Response: The Department disagrees with the commenter's assertion that lack of specific language regarding the requirement for a PRTF to maintain an emergency preparedness program is an "unresolvable procedural deficiency" that requires the Department to amend the rule and re-promulgate the rulemaking. As the commenter notes, federal regulations governing PRTFs require these facilities to maintain an emergency preparedness plan. The rule specifically states that PRTF services are governed by specified federal laws and regulations, including 42 CFR §441.184. Additionally, the requirement for an emergency preparedness program is explicitly included in 10-144 CMR Chapter 36, the Children's Residential Care Facilities Licensing Rule, which was promulgated simultaneously with this rulemaking. The Department believes that these provisions are appropriately included in the in the licensing rule, and makes no changes based on this comment.

Commenter 10:

102. The commenter stated that they understand the need for an additional level of care. The commenter shared that they have received calls from families whose loved ones have been stuck in an emergency room, discharged quickly from residential or placed in correctional settings. The commenter is also concerned about insuring adequate funding exists for community based services such as Section 28: In Home Support and Specialized. There are many people languishing on waiting lists for this service. Funding one should not mean inadequate funding another.

Response: The Department appreciates the commenter's support. The Department also agrees that both inpatient services, including PRTF services, and outpatient services, including Section 28, are vital to the maintenance of a comprehensive system of care for children with mental health needs. The Department's intent in introducing the PRTF service is not to diminish funding or support for outpatient services, but to complement these services by providing additional options for youth in need of inpatient support. No changes made as a result of this comment.

103. The commenter suggested that the Department should seek input from families by providing:
- A parent or guardian must be involved in all aspects of care from the Treatment Planning Team, Discharge Team, Transition Plan etc.
- Has the Department reached out to the families who child(ren) are currently out of state in a Residential Facility for their involvement of planning for this PRTF (they have lived experience which is critical when looking at a new service being offered.
- Please reconsider the time limits of maximum restraint and seclusion, they seem to be too long
- Treatment plans should contain a transition discharge plan and not just be giving a list of resources – there needs to be more of a warm hand off so families don't feel alone and isolated perhaps even some follow up calls to see how things are going

- Please insure that a behavior is not due to the fact of individual being in pain.

Response: The Department thanks the commenter for this comment. Please see the Department's response to comment 25 regarding inclusion of a parent or guardian on the planning team. The rule also includes comprehensive language at 107.07-08(A) regarding family centered practice expectations.

While the Department has not reached out specifically to families of children currently located out of state, the Department does maintain close communication with these children and their families. The department hopes that some children currently placed out of state will benefit from the addition of a PRTF service in Maine.

As regards the time frames for restraint or seclusion, the Department carefully considered this comment and others regarding the maximum time frames for restraint or seclusion. The Department decided to maintain the proposed language, which is consistent with the timeframes outlined in federal regulations, and shorter than those allowed per the Rights of Recipients. The department understands that the great majority of children will not require restraint or seclusion for the maximum allowed timeframes, but wanted to ensure that these interventions would be allowed to maintain the safety of the member. Additionally, the department amended the timeframe for medical evaluation following the initiation of a restraint or seclusion to 30 minutes, instead of the one hour proposed, to be consistent with the Rights of Recipients.

As regards discharge and transition planning, please see the Commenter's response to Commenter 9, Comment #15.

As regards behaviors related to underlying medical conditions, please refer to the Department's response to comment 24.

Commenter 11:

104. The commenter appreciates the Department's intention to help address the specified target population, the policy being advanced by the proposed rule is premature and ill-advised absent 1) a larger system review to accurately assess current and future need and 2) development of a strategic plan to adequately and effectively address those needs; something the Department has not done since 1997.

Response: The Department appreciates the commenter's suggestion regarding a review of the child mental health system in Maine. The Department also believes that allowing for a PRTF level of care is an important, and currently missing, component of comprehensive continuum of care. No changes made as a result of this comment.

105. The commenter stated that the children's behavioral health system has failed some of our most vulnerable youth. The commenter provided that a Department of Corrections profile of youth incarcerated at Long Creek Youth Development Center found that 85 percent had three or more diagnosed mental conditions; more than 75 percent had previously received mental health outpatient services; 80 percent had received family and community-based mental health services; and 49 percent of youth had an inpatient hospitalization for mental health problems. In addition, 42 percent of youth had spent time in a residential treatment program and 30 percent had been referred to the facility directly from one of those programs.

Response: The Department thanks the commenter for this comment. The Department proposed the PRTF as a piece of the continuum of Maine's mental health services and is intended to serve members

who have failed at or been deemed inappropriate for lesser levels of intervention. This rulemaking is a step to assure youth have access to the right treatment at the right time. No changes made as a result of this comment.

106. The commenter shared that a study conducted last year found the acuity of mental health problems of youth at Long Creek to be "extraordinarily high" and that the facility "houses many youth with profound and complex mental health problems, youth whom the facility is neither designed for nor staffed to manage." It is also important to note that many of the problems identified in the report also exist in other residential placement facilities in Maine, where staffing/training issues and a lack of individualized treatment can lead to the inappropriate use of force and the criminalization of behaviors that result from unmet needs.

Response: The Department thanks the commenter for this comment. Please refer to the Department's response to comment 22.

107. The commenter stated that to understand why so many youth with unmet mental health needs are ending up in Long Creek, the CCLP report called for a comprehensive systems assessment to review policies and practices of agencies that have significant responsibility in meeting the needs of at-risk youth, including DHHS; to evaluate the quality and effectiveness of existing services; and to identify service gaps. The commenter stated that in order to best serve the vast needs of youth, the state needs to know where the system is failing and why in order to make better informed choices about where to target the state's resources for the desired outcomes.

Response: The Department thanks the commenter for this comment. The Department will consider this suggestion. No changes made to the final rule.

108. The commenter stated that research on alternatives to incarceration shows that lengthy out-of-home placements in secure corrections or other residential facilities generally fail to produce better outcomes than alternative sanctions, cost much more, and can actually increase reoffending for certain youth. Alternatively, community-based programming has been proven effective in helping children with behavioral health issues and other complex needs and can successfully serve three to four youth in the community for the cost of confining one youth in an institution. The commenter criticized the Department in spending $3.5-$7million on a PRTF without first addressing the current waitlists for community-based services and enhancing that level of treatment. The commenter stated that the Department needs to conduct a "comprehensive assessment" of current services and "not wast[e] public resources to unnecessarily institutionalize children when more proven, less restrictive, and less expensive responses may be more appropriate and successful."

Response: The Department thanks the commenter for this comment. Please see the Department's response to comments 21, 22, 35, and 43.

Commenter 12:

109. The commenter discussed their history of supporting Maine's justice involved young people and strongly believe that youth are best engaged and supported when resources and programs are accessible in their home communities. The commenter stated that residential treatment is isolating, expensive and temporary. Maine does not need government dollars funding the operation of more facilities that sequester children out of sight.

Response: The Department agrees that inpatient and residential treatment is not to be considered lightly. The intention of the Department is simply to offer an additional level of care for individuals for

whom community based treatment is insufficient to meet their needs. The department agrees with the commenter that community based services are, for most children, the appropriate level of care. However, some children cannot be appropriately and safety served in the home setting. It is the Department's hope that these children can be better served in Maine based PRTFs than in other settings, including emergency rooms, out of state facilities, and, correctional facilities. No changes made as a result of this comment.

110. The commenter stated that the vast majority of young people can be supported and engaged in the community and requested that the state to put funds toward the home and community-based services that people clearly want. The commenter recognizes there are long waitlists for these services and suggested that the Department survey the youth and families to determine what they need prior to investing in PRTFs. The commenter suggests that DHHS consult the "most important experts," young people and families impacted by psychiatric and behavioral health conditions, in order to fully understand what ISN'T working in the current system before spending this kind of money.

Response: Please see the Department's response to Commenter 12, Comment #1. The Department appreciates the commenter's suggestion of engaging youth in conversations around best practices, and will take this under advisement.

Commenter 13:

The commenter suggested that the Department investing in PRTFs at this time is not smart for the three following reasons:

111. DHHS has not conducted a needs assessment and developed a comprehensive plan for mental Health Services since 1997. The commenter stated the Department has not engaged stakeholders such as DRM or Maine's youth in development of this level of care, and therefore, lacking any assessment or stakeholder engagement, the perception is that the development of PRTFs is intended to "warehouse" children regardless of efficacy of this setting for the particular youth's needs. The commenter discussed Minnesota's assessment of their services and development of their strategic plan to assure PRTFs are available to a limited population who might benefit from that level of care. The commenter stated that Maine youth and persons with disabilities merit the same careful attention and concern from state agencies and policy makers as persons in Minnesota, and Maine taxpayers merit the judicious expenditure of resources. Without a comprehensive assessment and careful process, PRTFs are little more than a "hail Mary pass."

Response: The Department held a public forum in February of 2018 to gather input from stakeholder in the development of this rule, and incorporated feedback received during the forum into the draft rule. The Department also held a public hearing as a part of this rulemaking, and gathered written comments. The Department does understand that a systematic assessment of the state's child behavioral health system has not been completed for many years, and will take this under advisement.

The Department is troubled to learn that there is a perception in the community that PRTFs will be used to warehouse children. This is certainly not the intent of the Department. In adding PRTFs as an allowable Medicaid service in Maine, the Department is seeking to address a defined issue. Specifically, the Department's intent is to create a level of care to serve children who are currently "stuck" in emergency departments, placed out of state and far from their families, or are children with mental health issues who are currently at Long Creek, but would be better served in a psychiatric facility. The Department would also like to note that PRTFs are not intended as long-

term placements. Children placed in PRTFs must be reevaluated at least every 60 days to ensure continued appropriateness of placement,

112. PRTFs are not supported by data for best practices for efficiently increasing mental health outcomes for children. Studies have shown that community-based alternatives are more effective and efficient. The commenter stated that Maine should follow the success of this study and expand its community-based programs instead of creating a new PRTF.

Response: The Department agrees with the commenter that the great majority of children are best served in the community with community based supports. The Department's intent in introducing PRTFs is to address the specific issue of children who cannot be safely served at home and currently have no appropriate setting within the state of Maine. No changes made as a result of this comment.

113. The commenter stated that GLAD is "simply incredulous" that the Department would seek to promote this level of care when community-based services are less expensive and more effective than their PRTF counterpart. The commenter stated that Maine has not taken the steps of other states to develop a comprehensive plan of mental health services, saving PRTF for only the most severe cases. The commenter stated that Maine is full of informed and compassionate people who could develop data-informed plans to ensure children have access to the right services in the right settings. Before approving these regulations, the DHHS, DOC and Department of Education should perform a comprehensive study to examine the current needs of young people and to forecast anticipated needs, as well as the availability and quality of services currently offered throughout the State, and make recommendations about the full range of options for putting our youth, and our communities, on the most productive track possible.

Response: The Department appreciates the comment and will consider a systematic review of the continuum of care in Maine for children with mental health needs.

Commenter 14:

114. The commenter stated that they understand that need exists for this level of care, they fear that developing this service will pull needed resources from a system of care that is "already stretched too thin." The commenter said that today they see that resources invested in evidence-based home and community treatment is far too low to meet the need in our communities. The commenter urges the Department to re-think this initiative to determine if there could be enhancements made to our current residential and community based services system of care for youth to cover this gap without investing in an entirely new infrastructure. The commenter reflected on the possibility of PRTF being a locked facility and then urged the Department to invest in evidence-based home and community based treatment instead. "This system is fraying at the seams."

Response: The Department thanks the commenter for this comment. Please see the Department's response to commenter 111.

Commenter 15:

115. The commenter discussed the history of Portland Outright in their support and advocacy for Maine's youth. The commenter shared that their organization has witnessed harm that happens to youth at residential programs and the juvenile justice system because of a lack of LGBTQ+ and trans-specific competency in the system as a whole. The commenter stated that 30-40% of Maine's incarcerated youth identify as LGBTQ+. The commenter shared that youth are retraumatized in the residential settings and juvenile justice system, and therefore it would be "morally and fully

irresponsible" for the Department to create new facilities without completing a system-wide assessment of current services and programs to assure no new harm happens.

Response: The Department appreciates the comment and understands the concern regarding the experiences of LGBTQ+. youth in residential settings. Please see the Department's response to comment 111 regarding the rationale for adding the PRTF service. The Department will consider a system wide review of services. The Department would also like to invite the Commenter to meet directly with state personnel to discuss the specific needs of the LGBTQ+ population. The commenter can contact Dean.Bugaj@maine.gov directly to arrange this.

116. The commenter stated that a facility-based approach perpetuates of isolation LGBTQ+ youth by cutting them off from supportive community and chosen family, like those built at Outright. The commenter suggested that an alternative to incarceration and institutionalization for LGBTQ+ youth is therapeutic, holistic, trauma-informed, community-based care and healing. The commenter urged the Department to not go forward with creating a PRTF, and instead invest in community-based solutions and addressing additional stressors like a lack of safe housing, inadequate physical and mental health resources, and discrimination that contribute to psychiatric conditions.

Response: The Department believes that PRTFs are a necessary addition to the system of care for individuals with mental health needs in Maine. However, the Department would like to emphasize that the eligibility criteria for PRTFs stipulated that community based supports must be inadequate to meet the needs of the member. The Department would like to meet with the Commenter to explore ways in which the Department can better meet the needs of the LGBTQ+ population.

Commenter 16:

117. The commenter discussed the Association for Maine Behavior Analysis (AMeBA) and its role in supporting the professional practice of behavioral analysis in Maine. The commenter expressed appreciation for the proposed regulation showing clear rights and protections for Maine's youth with severe behavioral health needs. The commenter stated that "AMeBA sincerely appreciates the intent of the proposed regulations to protect the safety and rights of some of the most vulnerable youth in our state."

Response: The Department thanks the commenter for the comment and appreciates the support in this endeavor.

118. The commenter addressed the Department's proposed definition of time out. *Time Out* (p. 3) – The use of the term *Time Out* in the proposed regulations may lead to confusion among providers, including those providing Ancillary Services, and in particular Board Certified Behavior Analysts (BCBA), as this term carries implications in its technical and practical implementation for BCBAs. The proposed definition states:

> **Time Out** means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control. (p. 3)
>
> The applied definition of *Time Out* means "the withdrawal of the opportunity to earn positive reinforcement or the loss of access to positive reinforcers for a specified time, contingent on the occurrence of a behavior" (Cooper, Heron, & Heward, 2007, p. 357). From this

perspective, the purpose of a time out procedure is to decrease the future likelihood of a particular behavior occurring. Adoption of the technical definition of time out would be beneficial to the provider team to ensure consistent interpretation and application of this procedure among team members.

Response: The Department thanks the commenter for this comment. The proposed definition of "time out" is consistent with Federal guidance in 42 C.F.R. 483.352, but the Department understands the commenter's concern that the current definition of "time out" may lead to confusion in the and may result in an inconsistent application of the intervention. The Department also recognizes that many types of practitioners may employ this intervention, and therefore the definition needs to be clear so that individuals with multiple types of backgrounds and training may successfully utilize this intervention when necessary. Therefore, the Department has modified the definition of "time out" in an attempt to further clarify expectation to ensure consistent application of the intervention. The new definition is as follows:

Time Out is intended to remove the resident from positive reinforcement of a particular behavior that has negatively impacted his or herself and/or others. Time out may include the loss of access to positive reinforcement within a particular setting and/or the restriction of a resident to a designated area for a period of time for the purpose of providing the resident an opportunity to regain self-control. During a time out, a resident must not be physically prevented from leaving a particular area.

119. *Functional Behavior Assessment (FBA)* – We very much appreciate the requirement for the positive behavioral support plans to be informed by an FBA (pp. 20-21), and as such, would strongly recommend that the regulations include a definition of FBA. Without a consistent definition of the assessment, MaineCare members are at risk of receiving FBAs "in name only." We offer the following sample definition for the Department's consideration: ***FBA*** *is a problem-solving process that identifies the individual and environmental variables contributing to occurrences of challenging behaviors for the purpose of designing individualized behavioral interventions*.

Response: The Department thanks the commenter for this comment. The Department appreciates the suggested definition and has adapted it within the final rule.

120. *Behavioral Support and Management Standards* – Again, we sincerely appreciate the requirement for behavioral interventions to be based on an FBA and provided by a qualified clinician. At a minimum, an FBA involves indirect and direct assessment procedures to identify and describe current levels of the challenging behavior, the contexts in which challenging behaviors occur, individual variables (e.g., skill deficits) that contribute to occurrences of challenging behaviors, antecedent variables that occasion and evoke challenging behaviors, and reinforcing consequences that maintain challenging behaviors. We recommend that a "qualified" clinician" be further defined, to include the level of training required to competently conduct an FBA. Sample qualifications may include the requirements that evaluators must be professionally credentialed and have training and supervised experience in behavior analysis and conducting FBAs.

Response: The Department thanks the commenter for this comment. The Department agrees that individuals completing Functional Behavior Assessments should have adequate training to be able to conduct an FBA properly and effectively. The rule has been modified to include the criteria that an individual completing an FBA must be clinical staff as described in 107.02-04 or a Board Certified Behavior Analyst with specific training in functional behavioral assessments.

121. The proposed *Behavioral Support and Management Standards* require ongoing monitoring, review, and adjustment to positive behavioral support plans based on the individual's response to treatment (p. 21). Further, the procedures require that the contents of behavioral plans include the use of adaptive and prosocial behaviors. Additional specificity in this area would be beneficial to ensure consistent practice across providers/service agencies. Operational definitions of the target behavior(s), antecedent interventions that reduce the likelihood of challenging behavior, teaching and reinforcement strategies to strengthen prosocial replacement behavior(s), and responsive procedures to reduce the future probability of challenging behavior are essential aspects of a comprehensive positive behavioral support plan and as such should be included as required components. Further, establishing requirements for direct behavior recording and *weekly* analysis of the data would allow close, continuous contact with relevant outcome data (Bushell & Baer, 1994), and would therefore lead to more timely treatment decisions and, in turn, the potential for more rapid progress for individuals receiving treatment.

Response: The requirements in policy are intended to be general guidelines to allow for flexibility based on individualized needs of the member. It appears the suggestions offered by the commenter specially describe activities that would ordinarily be performed by a BCBA. It should be noted that reimbursement for BCBAs is not included in the per diem rate for PRTF services. BCBA services are separately reimbursable. BCBA services and the process described by the commenter may not be required for every member.

122. *Use of Time Outs* – As noted previously, the technical application of *Time Out* is intended to reduce the likelihood of future occurrences of a behavior by restricting access to positive reinforcement for a designated period of time. In practice, the procedure may be implemented in any environment, and does not require restriction of an individual to a designated area, as indicated in the proposed definition (p. 3). For example, for a challenging behavior that is maintained by positive reinforcement in the form of access to attention, planned ignoring may be implemented as a prescribed time out procedure (i.e., time out from attention) for a designated period of time following the occurrence of the target behavior. This practice can be implemented in any environment, under most conditions. The distinction that "time out may take place away from an activity or from other members, such as in the member's room (exclusionary), or in the area of activity of other members (inclusionary)" (p. 28) is clear and consistent with the technical application of the procedure. The language may be confused, however, with that used in the definition which states, "Time Out means the restriction of a resident for a period of time *to a designated area…*" (p. 3). To ensure consistency between the definition and practice of *Time Out* within the regulation, it is recommended that "to a designated area" be removed from the definition.

Response: The Department thanks the commenter for this comment. Please see the Department's response to comment 118.

Commenter 17

123. The commenter discussed their association with the Maine Association for Community Service Providers (MACSP) and what the organization represents, and expressed appreciation for the "time and attention the Department has put into the creation of these regulations to try to address youth in out of state placement, youth stranded in psychiatric hospitalization with no safe discharge option, youth stranded in emergency rooms with no safe placement, and incarcerated youth in need of mental health treatment."

Response: The Department thanks the commenter for the comment and appreciates the support in this endeavor.

124. The commenter expressed concern for the current state of community based services and the "lack of prompt and consistent supports" for youth with disabilities, and suggested the Department focus on early intervention with children prior to determining a more restrictive setting is necessary. The commenter shared an example of current challenges with a community-based service, Section 28, and stated the service rate is unable to sustain the service, resulting in provider closing and increasing waitlist for services. The commenter stated that leaving the needs of community-based services unaddressed results in driving children into crisis by "depriving them of basic needs and ensuring their dependence or more intrusive, expensive, and institutional service."

Response: The Department thanks the commenter for this comment. Please see the Department's response to comments 21, 35, and 43.

125. The commenter stated that they are not convinced PRTF is the least restrictive environment necessary to meet the needs of the members identified in the rulemaking documents. The commenter expressed concern of the rulemaking's implication in the service system where "children cannot currently access community-based treatment." The commenter shared information on a study referenced by Commenter 9 on the cost effectiveness of community based services versus PRTFs, and suggested that should the Department move forward with PRTFs, that the Department review the referenced study and clarify the factors which differentiate Maine from its findings.

Response: The Department thanks the commenter for this comment. Please see the Department's response to comment 124.

126. The commenter suggested a "small time-limited and efficiency-based workgroup" to assess Maine's needs and create a strategic plan to address current concerns and meet the needs of Maine's children with disabilities.

Response: The Department thanks the commenter for this comment and will consider this suggestion. No changes made to the final rule.

Commenter 18

127. The commenter shared that she is a parent of a son with severe autism and bi-polar disorder characteristics who has experienced children's psychiatric residential treatment in Maine. The commenter called this "an eye opening and horrific experience for him and our family." The commenter shared background on her son and his history of professional supports. The commenter stated that a lack of steady workforce required her son to seek services out of state and was unable to return to Maine 8 years later after being funded through an adult waiver. The commenter discussed the lack of adequate workforce, service funding, and hospital beds equipped to support individuals with disabilities similar to her son. The commenter shared that provider refusals to serve her child resulted in psychiatric treatment as the only option in Maine, where that provider refused to adequately care and coordinate with other medical professions for a comprehensive evaluation, resulting in inadequate care and elongated time to complete the necessary appointments. This meant her child remained in high-cost psychiatric care longer than necessary. The commenter continued to discuss her child's situation and reflect on how services has affected him. Based on the commenters experience, the following comments were provided:

a. The state of Maine needs to strengthen prevention services for children to minimize the need for psychiatric residential facilities:

1. Eliminate wait list for in-home support for children

2. Make accessing small 24/7 neighborhood group homes more readily available for children rather than out of state placements or larger more institutional like placements.

3. Increase workforce rate for speech therapists as communication is critical to eliminate/reduce aggression.

4. Make sure rural areas have access to preventive services

5. Make sure all children have access to special healthcare needs services. Currently it is difficult to reach Title V professionals. When money is coming into our state for this, how is it being used? As prevention is related to how many people will need more intensive health, this is a relevant question.

b. All Psychiatric units need to be able to provide either within their unit or in collaboration with a hospital, access to a comprehensive evaluation. Medical issues due to pain need to be ruled out. Because hospitals are so ill-equipped to deal with people with behavioral issues it may be impossible to do this prior to being admitted. A psychiatric unit should work with hospitals to expedite a comprehensive evaluation if it is needed within an individuals stay.

c. Make sure there is strong family centered care coordination with other specialists within the unit and outside of the unit (if needed).

d. A family centered approach that includes families as equal team members will keep the process most efficient.

e. Any Psychiatric residential treatment facility needs to collaborate with community providers team members before, during and after the visit. There need to be clear transition plans developed.

f. Any procedures using holds needs to be closely monitored, tracked with efforts to minimize them. Holds need to be of short duration. An hour is excessive.

Response: The Department thanks the commenter for this comment. The Department appreciates the commenters concerns and suggestions from a parent perspective on supporting your child. Many of the concerns raised are complex and may not be easily solvable. The Department would like to emphasize that the wait list for children's services is not Department imposed, but rather a result of lack of providers. The Department manages the wait list in an attempt to fairly assign members to available resources but does not cap spending on children's behavioral health services in any way. The Department is acutely aware of the workforce issues impacting a large range of Medicaid funded services, particularly in rural areas. Increased rates alone may not be enough to entice potential employees to relocate to these areas and reduce wait-lists. The Department is certainly open to suggestions regarding ways in which to address our systemic workforce challenges.

As regards the suggestion that the Department fund neighborhood group homes, MaineCare does currently fund Appendix D PNMIs, which provide community based residential treatment for children with mental health and developmental diagnoses whose needs cannot be met in a home environment. Because these are state plan services, the Department cannot dictate the geographic areas in which the PNMIs operate. Rather, Appendix D PNMIs can be operated by any "willing and qualified provider" in any part of the state.

As regards preventive service, MaineCare reimburses primary care providers, specialists, and behavioral health providers for a range of preventive services. These are generally reimbursed on a fee for service basis, meaning that a MaineCare participating provider provides a service to an eligible member and is reimbursed according to a set rate. Medicaid and Title V are separate funding mechanisms. Title V funding is provided via a block grant from the federal government and is allocated to Maine providers through the Maine Center for Disease Control and Prevention.

The PRTF rule does include language requiring that providers rule out organic causes of behaviors. Please see the Department's response to Comment #24.

With regards to the family role within the PRTF, the Department encourages a high amount of family involvement and has incorporated family-centered treatment standards in 107.07-08.A, where in part, the PRTF is expected to work with families to actively engage them in the member's treatment. Additionally, parents/guardians are expected to have a role in the Clinical Certification of Need, participate in weekly family therapy, and participate in treatment planning.

PRTFs are expected to collaborate with community providers and actively engage in a member's discharge and transition plan. The Clinical Coordinator has been designated as the staff member responsible to facilitate the discharge and transition process.

The Department appreciates the concern on intrusive interventions. Intrusive interventions are highly monitored by the PRTF and are only able to be ordered by a physician. The Department has chosen the most strict regulation between Federal regulation and the Rights of Recipients of Children who are in Need of Mental Health Treatment when determining appropriate time-frames for the various intervention, monitoring, and follow-up. The use of interventions also are required by Federal regulation to have a debriefing process including the member and family after each occurrence. The Department takes intrusive interventions seriously and recognizes that any intervention requires a high level of scrutiny

Commenter 19:

128. Commenter 19 stated that she is an assistant District Attorney in Cumberland County specializing in juvenile prosecution for the past 20 years. The prosecution bar believes that healthier children benefit everyone in Maine, making communities safer and us more prosperous, and as such we have a vested interest in the mental health and well-being of our youth. In the rule, the commenter felt guardianship was ambiguous, and encouraged the Department to look at how guardianship plays out for youth committed to Long Creek Youth Development Center, into the Department of Correction custody, and to what role the Department plays and what role the parents play. The commenter would like clarity on this role beyond participation as a team member. The commenter questioned youth elopement and if facilities will be required to be locked. She stated that if not, there should be a protocol regarding elopement.

Response: The Department thanks the commenter for this comment. The PRTF is a treatment service that will provide services to MaineCare members regardless of custody status (DHHS, private guardian, DOC). Regardless of custody status, the youth's family and natural support system will be involved in treatment planning and participate in treatment as deemed appropriate by the youth's clinical team. Regarding elopement and a requirement for facilities to be locked, CMS does not require PRTF's to be locked, and the Department is following that guidance; however, the Department is also expecting that the PRTF will keep its members safe and have clear policies and procedures to address handling emergency safety interventions, which will be reviewed with the member and his or her parent/guardian upon intake. No changes made to the final rule as a result of this comment.

129. The commenter stated that she had two female juveniles in the court asked to be committed to Long Creek Youth Development Center because that was the only place that they would can feel safe. The commenter stated that "if we as a state offer only secure confinement in a correctional facility to the youth who are asking adults to keep them safe…if that is the best we have to offer, we should all be ashamed."

Response: The Department thanks the commenter for this comment. The Department shares the commenter's concern and has proposed the PRTF, in part, to attempt to address placing youth with mental health concerns in the most appropriate setting. No changes were made to the final rule.

130. The commenter shared that she felt this level of service (PRTF) is required, and necessary for members with mental health issues who have corrections involvement. The commenter suggested smaller, more homelike environments opposed to an institutional setting.

Response: The Department thanks the commenter for the comment and appreciates the support in this endeavor. Policy does not direct providers to develop programs in any particular manner. Therefore prospective providers have flexibility in the design of their PRTF program. No changes were made to the final rule.

131. The commenter had a question about transitioning home, especially for youth who would be transitioning to another placement, independent living, college, or with a family member. The commenter thought there was some preference for members to transition home, but must consider all children will not go home. The commenter stated that youth "vote with their feet" and that the system needs to account for youth eloping if they do not like the situation or environment they have discharged to.

Response: The Department thanks the commenter for this comment. The Treatment Planning Team is responsible for developing the Discharge Plan that would be individualized to each members' need and situation. Part of the function of the discharge plan is to evaluate what services and supports will be necessary upon discharge to assure a successful transition. The Clinical Coordinator will have a role in facilitating the member's transition to assure its success. No changes were made to the final rule.

LIST OF CHANGES TO FINAL RULE

1. Pursuant to Comment 3, the Department added ADHD as a qualifying diagnosis in Appendix A of this policy.

2. Pursuant to Comment 8, the Department has added Private Non-Medical Institutions as a consideration of eligibility in 107.04-02.B.1.b.

3. Pursuant to Comment 14, the Department removed the definition of "Drug used as a Restraint" and created a new section, 107.08 Medication Pro Re Nata (PRN) to address medication as needed for behavioral concerns.

4. Pursuant to Comment 23, the Department has updated the definition of 107.02-16 Serious Injury to state "…a serious injury to a member or a suicide attempt."

5. Pursuant to Comment 27, the Department has added language to 107.07-03.C to state, "Additionally, the Clinical Coordinator must serve on the member's team to develop the ITP and must facilitate the member's discharge and transition to aid in assuring a successful transition from the PRTF."

6. Pursuant to Comment 31, the Department has added the following language to 107.08-02.F regarding physical restraints, "Additionally, providers must not initiate or sustain any restraint that may hinder chest and abdomen movement."

7. Pursuant to Comment 32, the Department has added language to 107.09-01.C to clarify that only trained individuals may perform restraint or seclusion, "The restraint or seclusion is performed only by staff with specific training in these interventions."

8. Pursuant to Comment 61, the Department has adopted the Commenter's suggestion definition of "positive support strategy" as 107.02-11 Positive Behavioral Support Strategies.

9. Pursuant to Comment 64, the Department fixed the grammatical error.

10. Pursuant to Comment 66, the Department has updated any reference of "Treatment Team" to "Treatment Planning Team".

11. Pursuant to Comment 69, the Department has updated all page and section headers for accuracy.

12. Pursuant to Comment 77, the Department updated policy with a new section, "Medication Pro Re Nata (PRN)" as described above in #3, and additionally has updated 107.09-01-A by removing "and to prevent further serious disruption that significantly interferes with others' treatment."

13. Pursuant to Comment 78, the Department has added the definition of "caregiver" in 107.02-02 to read:

    Caregiver is an individual who is responsible for the custodial care, and protective oversight and supervision of a youth. Caregivers may include but is not limited to a member's parents, babysitter, immediate or extended family, other natural supports fulfilling this role, or professional staff providing protective oversight and supervision in a variety of settings.

14. Pursuant to Comment 85, the Department amended 107.05-04 to ensure a 30-day supply of medication unless medically contraindicated, versus the 7-day supply as proposed.

15. Pursuant to Comment 87 and as a result of legal review by the Office of Attorney General, the Department has updated 107.07-06.A.6 to include references to both the *Rights of Recipients of Mental Health Services who are Children in Need of Treatment* and the *Rights of Recipients of*

Mental Health Services. Additionally, this section requires PRTF staff to advise members and the member's parents or legal guardians, as applicable, of their rights and to offer them copies of the rights documents. The member's parent/guardian must sign acknowledgement that the member's rights have been reviewed and the publication has been received.

16. Pursuant to Comment 88, the Department amended 107.07-06.A.3 to the following: "Obtain an acknowledgement, in writing, from the member, or in the case of a minor, from the parent or legal guardian that he or she (or they) have been informed of and have received the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgement in the member's record."

17. Pursuant to Comment 94 and as a result of legal review by the Office of Attorney General, the Department has amended 107.09-04.A to require a face-to-face visit from the physician or nurse practitioner within 30 minutes of the emergency safety situation.

18. Pursuant to Comment 118 and subsequent review with the Office of Attorney General, the Department has amended the definition described in 107.02-20 "Time Out", for clarity.

19. Pursuant to Comment 119, the Department adapted the suggested definition of Functional Behavior Assessment as 107.02-07.

20. Pursuant to Comment 120 and as a result of legal review by the Office of Attorney General, the Department has amended 107.07-08.B.1 to state, "All individualized positive behavior support plans shall be based on a Functional Behavioral Assessment (FBA) by a qualified clinician or Board Certified Behavioral Analyst, with specific training in FBAs."

21. As a result of legal review by the Office of Attorney General, the definition of "Abuse or Neglect" has been updated to include and account for legal requirements for children and adults.

22. As a result of legal review by the Office of Attorney General, the definition of "Emergency Safety Intervention" has been updated to become consistent with federal language in 42 C.F.R. §483.352.

23. As a result of legal review by the Office of Attorney General, the definition for "Reportable Events" and the subsequent reporting section in 107.07-10.B has been removed.

24. As a result of legal review by the Office of Attorney General, the definition for "Restraint" has been updated to remove "drug used as a restraint."

25. As a result of legal review by the Office of Attorney General, the definition for "Serious Occurrence" has been updated to capitalize "Serious Injury."

26. As a result of legal review by the Office of Attorney General, the acronym, "CCON" was added to 107.04-02(A).

27. As a result of legal review by the Office of Attorney General, the Department amended 107.04-02.B.3.a to correct the citation within the provision.

28. As a result of legal review by the Office of Attorney General, the Department amended 107.04-02.B.C.2 to correct the acronym "CCON" and remove the statutory references.

29. As a result of legal review by the Office of Attorney General, the Department amended 107.05-01.A removing the language “within 24 hours of admission” and adding a cross reference to 107.07-07.A.

30. As a result of legal review by the Office of Attorney General, the Department amended 107.05-01.E to update citations to the correct references within policy.

31. As a result of legal review by the Office of Attorney General, the Department amended 107.05-02 to update citations to the correct references within policy.

32. As a result of legal review by the Office of Attorney General, the Department amended 107.05-04.B to add “member and the…” to more clearly align language with the analogous licensing rule.

33. As a result of legal review by the Office of Attorney General, the Department amended 107.07-01 to spell out Centers for Disease Control and Prevention.

34. As a result of legal review by the Office of Attorney General, the Department amended 107.07-02.B to change ‘facility director” to “medical director.”

35. As a result of legal review by the Office of Attorney General, the Department amended 107.07-03.A to more clearly comply with 42 C.F.R. §440.160a, 441.1.51(a)(1), and 441.156(c).

36. As a result of legal review by the Office of Attorney General, the Department amended 107.07-04.E Treatment Planning Team to better align with 42 C.F.R. §441.156(d).

37. As a result of legal review by the Office of Attorney General, the Department amended 107.07-05 to capitalize “Staff Clinician”, “Clinical Coordinator”, and “Administrator.”

38. As a result of legal review by the Office of Attorney General, the Department amended 107.07-06 to update the header from “Requires” to “Required.”

39. As a result of legal review by the Office of Attorney General, the Department amended 107.07-06.A for grammatical edits, to include “parents” in section 2, and to specify the restraint and seclusion policy in section 4, capitalize “State Protection and Advocacy Organization” in section 5, amend section 6 as described in #15 above, amend wording in section 7 for clarity while removing “children, youth, and families” and replacing with “from the member and his or her parent/guardian, when applicable. Additionally, section 7.b was amended with the same change to section 7 and the citation has been updated for accuracy. Section 7.c was amended to add “…member and his or her parent/guardian, when applicable…” and updated “child’s/youth’s” to say “member’s.”

40. As a result of legal review by the Office of Attorney General, the Department amended 107.07-07.A to clarify that providers shall conduct an initial assessment within 72 hours of admission and a comprehensive assessment within 14 of admission to the facility. Section 3 in 107.07-07.A. was updated to reflect the initial and comprehensive assessments. Section 4 was updated to include the assessment shall consider the “member’s expressed desires”, and section 7 was amended to consider the CANS assessment as part of the full comprehensive assessment. Additionally,

pursuant to this feedback, the Department additionally added the CANS assessment as part of the CCON team functions in 107.04-02.B.2.f.

41. As a result of legal review by the Office of Attorney General, the Department amended 107.07-07.B.1.a to differentiate an initial plan due within 72 hours of admission and a comprehensive plan due within 14 days of admission, consistent with the assessment as described in #40.

42. As a result of legal review by the Office of Attorney General, the Department amended 107.07-07.B.1.b and c to update citations to 107.07.04 and 107.07-07.A, respectively.

43. As a result of legal review by the Office of Attorney General, the Department amended 107.07-07.B was amended as follows:

- (1.k) was deleted;
- (1.g) was updated to read "meet the member's treatment objectives…";
- (1.i) was updated to include "both short-range and long-term…";
- a new provision (1.j.) was added to "describe the rationale for utilizing the prescribed treatment and services";
- a new provision (1.k) was added stating "specify the treatment and service responsibility, including both staff and member responsibilities in meeting the member's treatment objectives";
- a new provision (1.m) was added stating "include a list of needs identified in the Assessment process that are not addressed in the Treatment Plan and an explanation why the identified needs are not addressed."

44. As a result of legal review by the Office of Attorney General, the Department amended discharge plan criteria in 107.07-07.B.1.n as follows:

- (i) was updated to replace ITP with Treatment Plan;
- (ii) was updated to add "including staff who can assist the member in making referrals for other resources";
- (iv) was updated to add "planning" to treatment team, and to clarify the discharge plan will be reviewed at every plan review meeting and no less than every thirty days.

45. As a result of legal review by the Office of Attorney General, the Department amended 107.07-07.B.2 as follows:
- (c) amended to add "or sooner as clinically indicated by the treatment planning team";
- (c.ii) amended to replace "beneficiary's" with "member's";
- (d) – Be reviewed by a physician at least every 60 days - was removed;
- (e) amended to add "member and the member's…" and "if applicable" after parent/guardian.

46. As a result of legal review by the Office of Attorney General, the Department amended 107.07-07.D.1 to update the citation to read 107.05-01.D.

47. As a result of legal review by the Office of Attorney General, the Department amended 107.07-08 by replacing occurrences of child and adolescent with "member." Additional changes are as follows:

- (A.1) has added language to reflect treatment tailored to a return to family when possible and to a community. Additionally, this provision has amended to expect family partnership in treatment barring any limitations on participation. Treatment Plan has been capitalized;
- (A.2) has been updated for readability to state "…work with the member and his or her family" and the term "team" has been removed for clarity;
- (A.4) has been amended to clarify the "Treatment Planning Team shall address…";
- (A.5.d) has been amended to describe limits placed on family participation "including but not limited to protect the member's welfare, as a result of a protection from abuse or other court order, or a member age 18 years and older or an emancipated minor who does not consent to family participation";
- (B) has updated the prefatory paragraph to read as follows: "The PRTF shall practice positive behavior support strategies. Interventions are designed to modify member behavior should be individualized, respectful, developmentally appropriate, related to the issue at hand, flexibly applied, and designed to help the child master age and developmentally appropriate skills", and the phrase "all individualized positive behavioral support plans shall" has been deleted;
- (B.1&2) have been updated to add "All individualized positive behavior support plans shall…" with grammatical edits completed. B.2.a was updated to include "The member's trauma history shall be considered in determining the most effective means to de-escalate behavior."

48. As a result of legal review by the Office of Attorney General, the Department amended 107.07-09 as follows:
    - (C) to add "staff competency in the use of CPR…";
    - (G) to remove "in de-escalation and intervention techniques";
    - (H) to update the reference to (B) of this section.

49. As a result of legal review by the Office of Attorney General, the Department amended 107.07-10 as follows:
    - Title of section amended to "Reporting of Serious Occurrences" and each occurrence of "Serious Occurrence" in subsections have been capitalized.
    - (A.2) updated to add (OCFS) acronym and (A.4) updated to state "The Department's State Protection and Advocacy Agency."
    - (B) was amended to read "Reports must be made by the close of business the next business day following a Serious Occurrence."
    - (E) a new provision was added, "Staff must document in the member's record that the serious occurrence was reported to the agencies as required in this provision, including the name of the person to whom the incident was reported."
    - (G) was updated to state "In the event of a member death, the following additional reporting and documentation must be made"
    - (H) a new provision was added, "In certain circumstances, additional reports must be made to Child Protective services for youth under 18 years old per 22 M.R.S. § 4011-A, or Adult Protective for individuals 18 years and older per 22 M.R.S. § 3477."

50. As a result of legal review by the Office of Attorney General, the Department amended 107.07-10 to remove "B. Other Reporting Requirements" and Appendix C, the Reportable Events Matrix.

51. As a result of legal review by the Office of Attorney General, the Department amended 107.09 introduction to update the citation to Part 483. Additionally, a sentence was added "When there are conflicting provisions in these sources, the provision that provides the member the most protection applies."

52. As a result of legal review by the Office of Attorney General, the Department amended 107.09-01 as follows:

- (A) added language to describe the intervention as "absolutely" necessary and clarified protection from physical harm;
- (B) was updated to be consistent with federal language using "emergency safety situation";
- (C) updated to add "medical conditions" as a consideration and changing "should" to "must" in the third sentence;
- (D) removed reference to chemical restraint;
- (E) added a new provision "Locked seclusion is prohibited. The member may not be confined alone to any area with the door locked, barred, or held shut by staff";
- (F) added a new provision "For minor members, the Treatment Planning Team must decide and document in the Treatment Plan whether to allow restraints to be employed on a particular member in the event of an emergency safety situation and where the requirements of this section are met".

53. As a result of legal review by the Office of Attorney General, the Department amended 107.09-02 as follows:

- (A) added the following "The order must be the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.";
- (B) added a new provision "An order for restraint or seclusion may be given after an examination by a physician or nurse practitioner. In the event neither are available, a registered nurse, acting in consultation with and in accordance with protocol approved by the Medical Director, may conduct the examination and approve the emergency safety intervention";
- (C) deleted reference to the written standing order and replaced with "An order for restraint or seclusion must not be written as a standing order or on an as-needed (PRN) basis. An order for restraint or seclusion may be given only during or immediately after the emergency safety situation arises";
- (D.4) updated for consistency with federal regulation to read "emergency safety intervention…" and to add "…and the conditions under which the member may be sooner released";
- (E.3) deleted (within one hour…)
- (E.4 – now E.3) updated to designate signed order in the member's record;
- (F) "in the event of an emergency situation…" deleted and replaced with "If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse, while the emergency safety intervention is being initiated by staff, or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted to order restraint or seclusion must verify the verbal order in a signed written form in the member's record. The physician or other licensed practitioner permitted to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention";
- (G) updated to add "Additionally, providers must not initiate or sustain any restraint that may hinder chest and abdomen movement."

54. As a result of legal review by the Office of Attorney General, the Department amended 107.09-03 as follows:

- (A.2) added new provision "Every member placed in restraint shall be released as necessary to eat, drink, bathe, toilet and to meet any special medical orders. Members in restraint shall have each extremity examined and the restraint loosened, sequentially, no less frequently than every fifteen (15) minutes. In instances in which blanket wraps are utilized for restraint, the member will be released and examined no less frequently than every hour";
- (A.3) added new provision "A special progress/check sheet shall be maintained for each use of restraint. In addition to documenting the requirements of this provision, a description of the member's behavior as observed shall be noted on the special progress/check sheet every fifteen (15) minutes";
- (A.4) amended "other licensed practitioner" to "nurse practitioner";
- (B.1) grammatical edits;
- (B.2) added new provision "Every member placed in seclusion shall be released, unless clinically contraindicated, at least every two (2) hours to eat, drink, bathe, toilet and to meet any special medical orders";
- (B.3) added new provision "A special progress/check sheet shall be maintained for each use of seclusion. In addition to documenting the requirements of 107-09.03.B.2 above, a description of the member's behavior as observed shall be noted on the special progress/check sheet every fifteen (15) minutes";
- (B.5) amended "other licensed practitioner" to "nurse practitioner".

55. As a result of legal review by the Office of Attorney General, the Department amended 107.09-04.A to change time frames from one hour to thirty minutes, require a face-to-face assessment, and require "documentation of the physician's or nurse practitioner's examination must be entered into the member's record."

56. As a result of legal review by the Office of Attorney General, the Department amended 107.09-04 to add a new provision (B): "Thereafter, the need for a member's continuation in the emergency safety intervention shall be re-evaluated every two hours by a nurse. The nurse shall examine the member in person. For a member subject to an order of seclusion, the examination may be conducted outside the seclusion area; the nurse shall note the clinical reasons for selection of the examination site. For a member subject to an order of restraint, the examination may be conducted with the member free of restraints; the nurse shall note the clinical reasons for selecting whether the member is examined in or free or restraints. The nurse shall assess the member to determine whether the intervention is absolutely necessary to protect the member from causing serious harm to self or others. If the nurse finds these conditions are still met, then the emergency safety intervention may be continued if the physician's or nurse practitioner's order has not yet lapsed. Should the member not need continued seclusion or restraint, the nurse shall release the member even if the time frame of the original order has not yet lapsed. Documentation of the nurse's examination must be entered into the member's record."

57. As a result of legal review by the Office of Attorney General, the Department amended 107.09-04.C to state "In addition to the above criteria, examinations conducted under this section include, but are not limited to:"

58. As a result of legal review by the Office of Attorney General, the Department amended 107.09-05.C to delete the following sentence "The periodicity of monitoring should be based on the provider's assessment of the member's individual needs."

59. As a result of legal review by the Office of Attorney General, the Department amended 107.09-06.A to update citations to reflect current assignments within this section and a minor grammatical edit.

60. As a result of legal review by the Office of Attorney General, the Department amended 107.09-06.B to include "or has a legal guardian." 107.09-06.B.2 updated "situation" to "intervention."

61. As a result of legal review by the Office of Attorney General, the Department amended 107.09-07.A to add "as applicable" following "…parents or legal guardians" in the fourth sentence.

62. As a result of legal review by the Office of Attorney General, the Department amended 107.09-07.D was deleted.

63. As a result of legal review by the Office of Attorney General, the Department amended 107.09-08 title was updated to read "Medical Treatment for Injuries Resulting from an Emergency Safety Intervention." 107.09-08.B.2 was amended to delete "and local" when discussing medical privacy laws, and state citation to 22 M.R.S. §1711-C and 34-B M.R.S. §1207 was added.

64. As a result of legal review by the Office of Attorney General, the Department amended 107.11-01 was updated to amend PNMI to PRTF.

65. As a result of legal review by the Office of Attorney General, the Department amended Appendix C, Required Minimum Staffing Requirement to describe the first occurrence of FTE as Full Time Equivalent and to specify the positions as "on-site."

66. As a result of legal review by the Office of Attorney General, the Department deleted Appendix D Duplicative and Concurrent Services.

67. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 18 to "Medical, Clinical, and Direct Care Costs."

68. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 22 to "Establishment of the Interim Rate."

69. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 23 to "Interim and Subsequent Rates."

70. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 24 to "Final Rates."

71. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 25 to "Final Audit of Interim Rates."

72. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 26 to "Settlement of Routine and Fixed Costs."

73. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 30 to "Deficiency Routine and Fixed Costs Rate," and updated all references to the "deficiency per diem rate" to "deficiency routine and fixed costs rate" throughout the document.

74. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Legal Authority and Principle 1.1 to correct legal citations.

75. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 1.3 to add an introductory paragraph "Providers of PRTF services are paid a statewide per diem rate for medical, clinical and direct care costs (direct care services), and paid a facility-specific rate for routine and fixed costs (room and board costs). The routine and fixed costs facility rate is informed by annual cost reporting performed by the providers using a state-developed cost report. The medical, clinical and direct care per diem rate is not cost settled. The routine and fixed cost rate is cost settled by the Department." Additionally, Principle 1.3A was given the header "Routine and Fixed Costs" and the payment system is described as an "interim payment system" resulting in one "cost settled interim rate for room and board." Principle 1.3B has been updated to reflect "Medical, Clinical, and Direct Care Costs" and explain they are reimbursed at a Per Diem rate. The following was added, "The per diem rate is a statewide rate and it is not subject to cost settlement."

76. As a result of legal review by the Office of Attorney General, the Department amended Chapter III to remove the definitions for "Fee for Service," "Per Diem Rate," "Room and Board," and "Secure Capacity."

77. As a result of legal review by the Office of Attorney General, the Department amended Chapter III to replace "room and board per diem rate" with "routine and fixed costs rate" throughout this section of policy.

78. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 2.1.1 to clarify the agreement as a MaineCare Provider Agreement, and removed reference to 42 C.F.R., Part 440, Subpart A.

79. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 2.1.3 to update citations to Chapter II, Section 107.

80. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 3.1 changed "per diem" to "interim" for clarity.

81. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 7.3 and 7.3.3 to update "per diem rate" to "interim rate."

82. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 15.1 to start, "As regards to the interim payment system…"

83. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 17.5 to change "Interest Expense" to "Interest Cost."

- 17.5.1 was amended to read "Allowable interest costs on both current and capital indebtedness will be reimbursed."
- 17.5.3 was updated to state, "In order to be allowable…"
- 17.5.3.3 was removed.
- 17.5.3.4 was renumbered and revised to read that the Department's Division of Licensing and Certification must prior approve refinancing of loans on fixed assets, and will pay the lowest

of the actual interest paid or the amount of interest the provider would have paid under the terms of the original loan, with the original loan meaning the Department approved loan.

84. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 18.1 to state that Medical, Clinical, and Direct Care Costs will be reimbursed to a per diem rate. Principle 18.2 was amended to adjust language reflective of the change in title for the section. The sentence starting “It is based on the staffing…” was deleted.

85. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 22.1 was updated to become the “Initial Rate” and specify that this is for the PRTF’s first year of operation and that the rate is subject to cost settlement.

86. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 22 to add 22.2 “**Subsequent Interim Rate**. For subsequent years of operation, the interim rate will be based on the most recent cost settlement. If a cost settlement has not yet been calculated, the interim rate will be based on the facility’s pro-forma.”

87. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 24 to state, “Upon final audit of each PRTF’s cost report, the Department will determine a final rate of each PRTF, which cannot be greater than one hundred percent (100%) of all the calculated and allowable fixed cost and routine cost components for that PRTF.”

88. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Principle 26.1 to amend the section to read, “The Department will reimburse facilities for the allowable and actually incurred routine and fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable routine and fixed costs actually incurred…”

89. As a result of legal review by the Office of Attorney General, the Department amended Chapter III Appendix I to amend the description for Revenue Code 1001 to include “(Per Diem),” and to amend the maximum allowance language for Revenue Codes 0169, 0184, and 0185 to identify the allowance as “Routine and Fixed Costs.”

90. As a result of legal review by the Office of Attorney General, the Department made various technical edits including amending section numbering, section titles, and typographical issues.