[redacted]

From: [redacted]noreply+5f1e3167a787cb24@formstack.com>
Sent: Thursday, March 24, 2016 1:52 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/24/16 1:51 PM

Name (optional)::	Ellen O'Gorman
Company/Organization (if applicable) (optional)::	New England Pediatric Care
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	CMR 150.003 (E)
General Regulatory Themes::	Building Codes/Accessibility Standards
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health / Nursing Home Regulations / specifically for skilled nursing facilities for children / New England Pediatric Care (N.E.P.C.) is one of the three pediatric skilled nursing facilities in the Commonwealth of Massachusetts, which provides nursing, rehabilitation and special education to the medically complex, neurologically impaired pediatric population. These children can be ventilator dependent, have tracheotomies, gastrostomy and naso-gastric feeding tubes, require IV therapy, or seizure management therapy. They are all totally dependent for all their activities of daily living. The patient's rehabilitation goals are met with individual and consulted on-site physical therapy, occupational therapy and speech therapy. The treatment provided includes developmental therapy, range of motion, oral motor feeding programs, splinting, casting, wheelchair and equipment management, as well as consultation to the special education programs of the individual children.
Describe the regulatory issue or observation::	The Medical Review Team regulations were established in the 1970's, and to attempt to work in this current health care environment 30+ years later, with such a laborious, antiquated, cost in-effective system is deplorable. The disrespect it tenders to hard-working, dedicated families with medically fragile children is also just not right. Right or wrong, in today's world, health care decisions need to be made in a quick cost effective and safe manner for any child, including one who is medically fragile with high acuity medical needs. With the burdensome MRT application, and lengthy time period (up to 10 business days for long and short-term requests) it takes for decisions to be made, this just does not meet with the standards in 2013. With the support of the legislature and Executive Office of Health and Human Services (EOHHS) back in 2000, the Medical Review Team was able to institute a sub

acute/post-hospitalization program for the pediatric nursing facilities which has allowed for some improvements for hospitalized children needing post-acute care. A lot can happen to a child and a family upon discharge from a hospital, be it an unsafe transfer home to a family who has not had the time to be educated to their child's changing medical needs, or with a transfer to a geographically less desirable chronic hospital which puts a greater burden on the family dynamics. However, this continues to merely be a stop-gap procedure, and is still met with inconsistencies, inefficient in time and process discharges from hospital, and it places an intermediary barrier between the families and the facilities, where proper health care decisions cannot be made between the families/pediatric nursing homes/physicians.
I have had the privilege over the past fifteen years of being a member of a national pediatric nursing home group, now incorporated as the Pediatric Complex Care Association; to establish standards and best practice for pediatric nursing homes, and to participate in conferences with many other members of the pediatric nursing home national community. I have worked with people who run pediatric nursing homes in Oregon, California, Florida, Illinois, New York, Virginia, Kentucky, New Jersey, Ohio, along with the other homes in New England. Nowhere is the admission process as political and bureaucratically controlled as here in the Commonwealth. Elsewhere, decisions are made the way health care decisions should be made. They are between the facility, the family, and the payor sources and in some cases, private or state agency case managers, who work with the children and their families. The parameters for admission are known and practiced by all, and decisions are made in the best interests of the child, the family, the facility, the payor sources and the community in an expedient and effective manner.

The current process and structure for certification for admission into a pediatric skilled nursing facility precludes our ability to provide short term, post-hospitalization sub-acute care to the pediatric population in a time-efficient, cost-effective manner that also shows the necessary respect and understanding towards parents and caregivers. Over the course of years, N.E.P.C. has received numerous urgent phone call referrals from parents or case managers, referring medically appropriate, neurologically impaired children, and we are not able to respond properly to maintain the well-being, safety and medical status of the children affected. You have no idea what it's like to speak with desperate parents, sympathize with them, agree with them on the inadequacies of the system, and not be able to do anything for their children. Any other consumer accessing adequate levels of health care in this Commonwealth does so in conjunction with their primary care physicians, their third party-payors, and the admission personnel of a nursing home. Severely disabled children of the Commonwealth would be better represented, and their interests better served by allowing them the same consideration in accessing medical care as the adult population. In today's limited resource environment, isn't merely having a multiply handicapped, medically fragile child, enough of an enormous burden, without having to compound the issues with antiquated, onerous, out-of-date regulations that add further liability to already overwhelmed parents. There are many parents of children at New England Pediatric Care who vividly remember the day of the Medical Review Team meeting as one of the worse days of their lives. Given that they have already received news that they have a severely medically fragile child, who has probably been tested with numerous life and death issues during their lifetimes; putting them before a bureaucratic government run board to plead their case in order for their child to receive needed medical care and support is very negative. The process, which does not encourage parents to attend, but which prefers to make their decisions behind closed doors, is overpoweringly disrespectful and dishonors those

parents.

Suggestions for improvements to the regulation::

The families who refer their children for long-term care at pediatric nursing homes do so after a great deal of soul searching and evaluation of their child's needs and their ability to meet those needs. Although the home care industry is a major asset to many of the families, often it is not enough, and try as they may, which they do, can sometimes be inadequate, either in the short-term regarding staffing issues, or for the long term depending upon the needs of the developing family. Families that utilize the pediatric health care system should have a say in accessing health care in pediatric nursing homes, for both short-term stays, sub-acute stays, as well as long-term care options, in addition to the home care options that are available for the. The parents of severely disabled children know exactly what it takes to responsibly care for a child in the home. Only after a great deal of long hard thought and with lots of resources providing various opinions to their situation, will they access long-term placements. We should respect parents' right to make choices without having to prove themselves to an intimidating bureaucratic committee. The more options there are available to children and families, (home care, acute-hospitalization, sub-acute short-term skilled nursing care, and long term skilled nursing care), the more likely it is that a child can remain an integral part of their social community and family life, in a less stressful and healthier environment. Generally speaking, once parents come to the decision to tackle the admission process for a pediatric nursing home placement, they are so burned out and exhausted that long-term placement seems to be the only option for them. If they had options and choices along the way of acute care, sub-acute, short term care, respite and home care, they would feel less trapped and more in control of their children's lives.

Relative to short-term admissions, the ability to admit a child for a long-weekend, a week, or even a month, to allow the child to receive 24/7 medical care, adjust sleep patterns, adjust medications, and/or give parents/caretakers a break from the 24/7 care they provide their children, along with being able to provide undivided attention to their other children is often a life-saver for the families with medically complex children. This program provides any number of children/families excellent supports. However, even this is limited to only a "select" group of children, because of the cognitive limitation caveat (short-term admissions will only be approved if child is under a 24 month level of cognitive functioning) that's placed on the approval process. I'm quite sure that a 12 year old medically complex, multiply handicapped child with a cognitive level equal to that of a 36 month old or a 48 month old child, or even higher, is equally deserving of this kind of intermittent care, as are their families. And if all adults, over the age of 22, who have skilled medical needs and live in the community with appropriate caretakers, are allowed a "respite" program in adult nursing homes, why is there a gap in those services for children under 22 years of age but over 24 months in development. That makes no sense, and it deprives that group of medically complex multi-handicapped children from receiving well deserved services, and for support to their families.

It is because of the aforementioned needs of this pediatric population, that NEPC asks to eliminate the Department of Public Health's Medical Review Team, and allow it to be replace with a screening process already in place for the adult long-term care, short-term care, sub-acute and respite care, that is compatible to the Medicaid system for admissions to skilled nursing facilities.

Thank

[redacted]

From: [redacted] <noreply+11044806ea1262c2@formstack.com>
Sent: Thursday, March 24, 2016 1:57 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/24/16 1:56 PM

Name (optional)::	On Behalf of all Patients/Familes of
Company/Organization (if applicable) (optional)::	New England Pediatric Care
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	150.003 (E)
General Regulatory Themes::	Children and Families
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health / Nursing Homes / Skilled Nursing Care Facilities for Children (SNCFC) (Level II)
Describe the regulatory issue or observation::	ACT RELATIVE TO ELIGIBILITY CRITERIA FOR NURSING HOMES SERVING PEDIATRIC RESIDENTS Fact Sheet This bill would eliminate the Department of Public Health's Medical Review Team and would replace it with a screening process for admissions to skilled nursing care facilities for children based on existing MassHealth screening and clinical eligibility criteria. There are three skilled nursing care facilities for children ("pediatric skilled nursing facilities") in Massachusetts that provide skilled nursing, rehabilitation and special education to medically complex, neurologically impaired multi-handicapped children. Under current law, the Medical Review Team (MRT) must approve any admission to a pediatric nursing facility regardless of the family's preference, resident's payment source or anticipated length of stay. The lack of expanded short-term MRT eligibility criteria (children presently have to have a cognitive level less than 24 months) has hindered the ability of pediatric facilities to provide short-term, sub-acute nursing care to all multi-handicapped, medically complex children less than 22 years of age. Even the shortened paper application and process for post-hospitalization has precluded a timely discharge process for acute care hospitals. To keep up with the health care demands of 2015, an appropriate hospital to pediatric SNF transfer would

shorten hospital lengths of stay, lower MassHealth costs between hospital cost and that of a SNF, allow for better continuity and approvals for third party payors, and better equip the complex children a more successful re-entry into their own homes and communities. The MRT process has also hindered facilities' abilities to contract appropriately with third party insurers, who could pay for up to 100 days of skilled nursing care per year, thereby saving the Commonwealth significant expense.

Suggestions for improvements to the regulation::

The MRT needs to be replaced with an up-to-date appropriate screening and eligibility process for sub-acute; short-term and long term admissions, based on objective MassHealth clinical criteria of skilled nursing needs, as is done with the adult community.

[redacted]

From: noreply@formstack.com
Sent: Thursday, March 24, 2016 5:36 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/24/16 5:36 PM

Name (optional)::	
Company/Organization (if applicable) (optional)::	
Address (optional)::	
Primary Phone (optional)::	
Email (optional)::	
CMR Number (If known): :	105 CMR 590.00
General Regulatory Themes::	Other
Please list the Agency or Agencies affiliated with this regulation::	MDPH Food Protection
Describe the regulatory issue or observation::	Some small businesses supported by MASS Food Policy/ (MDAR) wish to change regulations but with what regard to public health and safety requirements? (105 CMR 590). Sale of raw milk at retail, (recently associated with large outbreak and a death in another part of the country) - food processing from farms not in compliance with FSMA, locally sourced foods without oversight as to how it is processed etc.
Suggestions for improvements to the regulation::	Consistency with FSMA and Adoption of 2013 FDA Food Code / 105 CMR 590.00 after review based upon public health, safety, science, best pactices to prevent food borne illnesses.

[redacted]

From: [redacted]<noreply+6ba7c347d2c1a1c5@formstack.com>
Sent: Saturday, March 26, 2016 1:52 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/26/16 1:51 PM

Name (optional)::	Jim Landry
Company/Organization (if applicable) (optional)::	
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	105.003(E)
General Regulatory Themes::	Building Codes/Accessibility Standards
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health/Nursing Homes Skilled Nursing Care Facilities For Children (SNCFC((Level II)
Describe the regulatory issue or observation::	Medical Review Team has to approve any admission to a pediatric nursing facility regardless of the families preference or anticipated length of of stay. One year our family was denied SNCFC services even though our daughter had no change in her condition. Our daughter is 19 and requires 24/365 care. We had to use the threat of legal action to get approval. This was very stressful and totally unnecessary. This wonderful program is the only respite my wife and I receive. Losing this program could cause us to not be able to continue to care for her at home.
Suggestions for improvements to the regulation::	Eliminate the DPH's MRT Team and create a process that includes representation from physicians, pediatric care facilities, and a couple of parents. Having SNCFC services for families is critical for our long term wellness.

[redacted]

From: [redacted]<noreply+9e0ac4a33d1b1e01@formstack.com>
Sent: Monday, March 28, 2016 2:55 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/28/16 2:54 PM

Name (optional)::	Gail Walker
Company/Organization (if applicable) (optional)::	Massachusetts Perinatal Team
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	105 CMR 130.000
General Regulatory Themes::	Licensing and Permitting
Please list the Agency or Agencies affiliated with this regulation::	All of the hospitals in Massachusetts with maternity/NICU services
Describe the regulatory issue or observation::	Current regulations remain out of date for current national standards of practice.
Suggestions for improvements to the regulation::	Multiple-we would like to send full scope of recommendations for revisions in to DPH for review. We can provide a hard copy and a flash drive of all recommended changes. Please send name of contact person to remit changes to or we will send to the Commissioner. Please use contact information given above.

[redacted]

From: [redacted]<noreply+9e0ac4a33d1b1e01@formstack.com>
Sent: Monday, March 28, 2016 2:55 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/28/16 2:54 PM

Name (optional)::	Gail Walker
Company/Organization (if applicable) (optional)::	Massachusetts Perinatal Team
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	105 CMR 130.000
General Regulatory Themes::	Licensing and Permitting
Please list the Agency or Agencies affiliated with this regulation::	All of the hospitals in Massachusetts with maternity/NICU services
Describe the regulatory issue or observation::	Current regulations remain out of date for current national standards of practice.
Suggestions for improvements to the regulation::	Multiple-we would like to send full scope of recommendations for revisions in to DPH for review. We can provide a hard copy and a flash drive of all recommended changes. Please send name of contact person to remit changes to or we will send to the Commissioner. Please use contact information given above.

[redacted]

From: [redacted]<noreply+6afdc2e5d789d1d3@formstack.com>
Sent: Wednesday, March 30, 2016 12:18 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/30/16 12:17 PM

Name (optional)::	Candice McCubrey
Company/Organization (if applicable) (optional)::	
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	105.003
General Regulatory Themes::	Health Care
Please list the Agency or Agencies affiliated with this regulation::	Department of Public Health/Nursing Homes/skilled Nursing Care Facilities for children (SNCFC) (LEVEL11)
Describe the regulatory issue or observation::	Medical Review Team (MRT) must approve any admission to a pediatric nursing facility regardless of the family's preference, resident's payment source or anticipated length of stay.
Suggestions for improvements to the regulation::	Eliminate the Department of Public Health's Medical Review Team and replace it with a screening process for admissions to skilled nursing care facilities for children based on existing MassHealth screening and clinical eligibility criteria. My personal story is MRT denied short term respite care for my quadriplegic,non-verbal, tube fed, incontinent, 9 month cognitive developmental aged daughter. Apparently the MRT knows more than multiple doctors including a neurologist, rehabilitation doctor, orthopedist, cardiologist, primary care physician, GI specialist, mulitiple special education teachers that hold multiple Master's Degrees, social workers from various organizations, and her family. MRT is redundant YET has authority to disagree/overturn/deny recommendations made by medical professionals and DESPERATE families without EVER HAVING TO ACTUALLY OBSERVE THE CHILD. It just doesn't make sense. Either all the doctors, therapists, teachers, social workers, and I are right....or MRT is a bureaucratic hoop that is justifiably suspended for all special needs parents to be forced to jump through.

[redacted]

From: [redacted]noreply+cce385ba3a48ef86@formstack.com>
Sent: Thursday, March 31, 2016 5:00 PM
To: RegReform (ANF)
Subject: A Clearer Code: Regulatory Reform

Formstack Submission for form A Clearer Code: Regulatory Reform

Submitted at 03/31/16 5:00 PM

Name (optional)::	Michele Keefe
Company/Organization (if applicable) (optional)::	MA Adult Day Services Association (MADSA)
Address (optional)::	[redacted]
Primary Phone (optional)::	[redacted]
Email (optional)::	[redacted]
CMR Number (If known): :	105 CMR 158.000 & 101 CMR 310.00
General Regulatory Themes::	Health Care
Please list the Agency or Agencies affiliated with this regulation::	Executive Office of Health and Human Services Department of Public Health MassHealth

Describe the regulatory issue or observation::

Re: 105 CMR 158.000 Licensure of Adult Day Health Programs
101 CMR 310.00: Adult Day Health Services (MassHealth Rates)

Adult Day Health (ADH) Programs, which were previously only regulated by MassHealth, are now also required to be licensed and regulated by the Department of Public Health. New wide-ranging, costly requirements and unfunded mandates went into effect on January 2, 2015. We are seeking relief from some of the burdensome and unnecessary requirements, as outlined below, which are making it much more difficult for small businesses and nonprofit organizations to operate. Additionally, we are seeking fair compensation that covers the actual cost of providing the services in 2016 under the new regulatory scheme.

The MA Adult Day Services Association (MADSA) supported ADH Licensure, including the establishment of new suitability standards and licensee responsibilities, and regular program oversight. We had concerns involving serious issues in state funded health care services, including ADH, in other states potentially in MA. Therefore, we sought increased standards, oversight and protection for ADH participants in MA. However, we stated that it is critical to our 130 member programs and 14,600 participants, that the

essence of ADH be maintained. Further, we said that the new regulations, aimed at protecting participants and program integrity, must be carefully calibrated to ensure that the focus of ADH remains on the provision of excellent, participant-centered, flexible and efficient community based services provided by a multidisciplinary team. This is what makes ADH the cost effective and successful service that it is. We warned about the risks of moving toward the Nursing Facility-type requirements, that over-emphasizes paperwork and other unnecessary requirements, over direct patient care. We stated that we believe this is what has reduced, not increased, quality of care in Nursing Facilities and we did not want to see that happen to Adult Day Health programs. Further we stated that new costly requirements must be minimized to ensure the continued cost efficiency of ADH programs and that those requirements that the state decided to include must be funded to ensure the continued viability of these community based programs.

We met with the Department of Public Health, MassHealth and the Executive Office of Health & Human Services many times, most recently in November 2015 and respectfully requested that they adjust some of the new regulatory provisions and requirements that have had unintended, but damaging, consequences as outlined below. We also requested funding of any and all new mandates.

Then on March 21, 2016, MassHealth presented a rate proposal at the public hearing, which included NO increase for Adult Day Health (ADH) programs. This situation cannot be sustained.

Current MassHealth/state per diem reimbursement rates for ADH ($58.83/Basic, $74.50/Complex) are based on 2009 costs and have NOT been increased since 2012. MGL Chapter 118E, Section 13D, requires the "Executive Office of Health and Human Services (EOHHS) to establish the rates to be paid by governmental units for health care services on a biennial basis." But there had not been a rate hearing for 3 1/2 years, since October 2012. MGL also requires that payment rates be established to ensure reimbursement, "for those COSTS which must be incurred by efficiently and economically operated facilities and providers." However, the MassHealth proposal is NOT based on any analysis of current ADH costs, but rather on a decision not to increase ADH rates. (Per CHIA Memo in May/2015, "Overview Summary of Rate Options, 101 CMR 310) Dr. Christine Bishop, a Harvard trained economist testified that the proposed rates do not cover the costs of 70% of ADH providers and further, it does not fund ANY costs for new regulatory requirements effective in January, 2015.

The rate proposal, coupled with the unfunded mandates, has created an urgent situation for ALL ADH providers and threatens to close many programs statewide. Ten programs have closed since FY14, and 25 more, including many who testified at the ADH Rate Hearing, are at serious risk of closure this year unless they receive regulatory and rate relief. Again this is causing a fiscal crisis for many ADH programs and elders who have lost or are at risk of losing their services. Labor and all regular operational costs for ADH programs have increased since 2012. Additionally, the new burdensome, costly and unfunded regulatory requirements went into effect in January 2015, and are not funded under this proposal!

While previous ADH regulations lacked suitability standards and regular inspections, a number of the operational provisions, which were developed over 35 years, were working very well. We respectfully request that the Department of Public Health review changes especially to these requirements

outlined below, as there may be unintended and damaging consequences.

Suggestions for improvements to the regulation::

Re.: 105 CMR 158.000 Licensure of Adult Day Health
101 CMR 310.00: Adult Day Health Services (MassHealth Rates)

The MA Adult Day Services Association's Suggested Improvements to ADH Licensure Regulation 105 CMR 158.000 and 101 CMR 310.000 are as follows:

In Summary:

1. Provide funding or eliminate unfunded new operating requirements, with additional estimated annual operating costs ranging from $47,200 - $79,100+ per program. Overall estimated additional per diem/unit cost is estimated to be about $5 per person per day. (i.e. per unit) (Or about $7.5 Million annually industry wide.)

2. Eliminate or revise unnecessary, costly and damaging new regulatory requirements

3. Reimburse ADH Programs for unfunded one-time physical plant changes/expenses. ADH rates are set as a class rate and therefore programs are not reimbursed for their individual capital expenses.

4. Implement Adult Day Health rate adjustments (MH), based on the ACTUAL COST of providing the care, in 2016, which is $70 per day for the Basic level of service and $83.60 for the Complex level of care.

Details/Suggested Changes

1. Fund or eliminate the new requirement for an additional .5 FTE nurse.

The new ADH licensure regulations added the requirement for an additional .5 FTE Nurse for all ADH programs. (105 CMR 158.032). The new MassHealth rate proposal provided NO funding for this additional new nursing requirement. The approximate cost for this new requirement is at least $40,000/year per program. The net fiscal impact, industry wide, is conservatively estimated to be at least $3 Million annually, or an additional $2.50 for each per diem unit. (i.e. per person/per day). While MADSA does not necessarily oppose increased nursing staff, ADH Programs CANNOT afford this additional expense unless the state reimbursement rate reflects this significant additional cost. If this requirement is revised, it must be done in tandem with the reduction in unnecessary and burdensome new documentation, paperwork and other burdensome nursing requirements.

2. Eliminate the requirement for several new Consultants.

New Social Work, Occupational Therapy, Dietary, Physician and Pharmacist Consultants are now required for all ADH programs. The approximate Cost is at LEAST $7,200 per year per program. The net fiscal impact, industry wide, is conservatively estimated to be at least $1,08 Million annually, or an additional $1.00 for each per diem unit. (i.e. per person/per day).

All of the new consultant requirements should be eliminated. They unnecessarily burden nonprofit organizations and small businesses, drive up costs and do not add value to the service. If ADH participants require clinical services, such as counseling/therapy, ADH programs refer them for this

service through outside contractors, just as we do for Physical or Speech Therapy, for example. ADH programs operated successfully and efficiently for 37 years under the supervision and oversight of Program Directors, Licensed Registered Nurses and required dietary consultation under USDA Food Program requirements. SW, Dietary and OT consultants are unnecessary costs.

3. Revise the ADH Licensure regulations to allow the use of LPNs in ADH programs, as Nursing Facility regulations allow.

The new requirement precludes the use of LPNs in ADH programs unless an RN is present. This unnecessarily increases costs by an estimated $15,000/year per program. (158.032 B). The net fiscal impact industry wide is approximately $2.25 Million annually, or an additional $1.50 per unit. Additionally, this requirement decreases the quality of care by requiring programs to bring in temporary agency RNs who do not know the clients instead of using LPNs who have know the clients for years. In some cases this has led to job losses, requiring some ADH programs to lay off LPNs.

LPNs are allowed to operate independently in Nursing Facilities and in other settings. MADSA does not oppose the requirement for all ADH programs to employ an RN Director of Nursing and other RNs. However we do object to LPNs not being able to cover absences or vacations, for example.

4. Revise licensure regulations and revert to previous requirements, which allowed a slightly longer interval before ADH programs were required to bring in additional required staffing.

5. Revise Damaging Changes in ADH Licensed Capacity Requirements. Use the previous regulatory requirement, which had been working well for 37 years.

ADH programs must and always do stay under required Certified Occupancy Limits set by local fire/city officials. The capacity limits in the new DPH regulations are based on arbitrary judgments. We have asked DPH staff to consider using the previous regulatory requirement: Definitions: Certified Capacity - a capacity approved by the MassHealth agency as outlined in 130 CMR 404.412(H). Once a provider is approved, the AVERAGE DAILY CENSUS at the provider site must not exceed the certified capacity. MassHealth recognized that this definition was critical to the viability of ADH programs as attendance of frail elders fluctuates greatly. Requiring programs to never go over licensed capacity forces them to "under-book," or send vulnerable elders home, which had resulted in reducing services to participants and extreme reduction in program revenue.

6. Implement Adult Day Health rate adjustments (MH), based on the ACTUAL COST of providing the care, in 2016, which is $70 per day for the Basic level of service and $83.60 for the Complex level of care.
Retroactive implementation of the new rates* utilizing the most recent base year;
ADH rate adjustments retroactive to October of 2014, when a rate review was required, and when our current rates in essence expired.

7. Discontinue the MassHealth requirement to bill in 15 minute increments for attendance exceeding four hours, and allow full day reimbursement, as is done in Connecticut.

8. Expedited or emergency ADH rate implementation process;

9. ADH Rates and methodology that reflect the actual costs of providing the service (Per methodology changes implemented during the last rate review in 2012 - ADH Working Group recommendations);

10. ADH rates that reflect the significant new costs associated with the ADH Licensure regulations;

11. MassHealth should pay providers for at least 10 absences per year, similar to the bed-hold payments in Nursing Facilities and Rest Homes.