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Independent Regulatory Review Commission

RCPA
REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

August 9, 2019

To: IRRC Panel and DHS/OMHSAS

From: Jim Sharp RCPA Children's Division Director

Re: No. 3209 Department of Human Services #14-546: Intensive Behavioral Health Services

On behalf of RCPA and our members we provide the following comments for review and consideration. While the work to develop IBHS regulations to ensure that children and families in Pennsylvania have access to the most appropriate services is noted and timely, we cannot fully support regulation No. 3209 Department of Human Services #14-546-Intensive Behavioral Health Services in its current form.

Within these comments several overarching concerns arise that should give pause when considering the potential impact to children, families, providers and the system

The Department and the statewide IBHS Workgroup took great care to reimagined service platform similar to the current BHRS model of individual services, ABA services and group services; and designed with the capacity to deliver those services to youth on the autism spectrum or with emotional and behavioral needs interchangeably; as stated in the DHS Preamble response

"This does not mean that children, youth and young adults cannot receive services other than ABA or that children without ASD cannot receive ABA services. Rather it means that children, youth and young adults must receive services from staff who are licensed"

However, in section 5240.71 Staff Qualifications for Individual Services, the staff qualifications for those who deliver non -ABA individual services are the same or similar requirements of those delivering ABA services, and discounts training, model expertise and success in delivering non-ABA interventions such as Cognitive Behavioral Therapy. It should be noted that CBT, along with other non-ABA interventions have proven successful with children with ASD and other emotional and behavioral needs, which is consistent with the DHS/OMHSAS language in the Preamble. Additionally, this defies the logic in creating three platforms of individual services, ABA services and group services and more importantly negates family choice for the interventions most effective for their children

In the end, this strategy is tantamount to creating a paradigm shift to eliminate other viable treatment strategies for these children, with the assumption that ABA interventions solely are successful for ALL children.

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The potential outcome could be denial of access to services for tens of thousands of children with an ASD diagnosis whose current needs are successfully met through non-ABA interventions. Lastly, will these adverse outcomes challenge the core mission to reduce higher levels of service and care and potentially impact the safety of this population in their homes, schools and communities?

The financial and collateral ramifications of the enactment of these new standards and the perception that the fiscal implementation values come with cost neutrality for providers should be based upon an actualized review not supposition.

Concerns:

1. Service and Capitation rates not being tethered to pre-implementation activities including BH MCO authorization and process pathway development

2. Increased staffing to meet the needs of service without readjusted rates to meet increased costs.

3.. Supervision standards increase the amount of non-billable and non-service time that will be dedicated to these activities which is not billable in the Medicaid system.

Recommendation: Reasonable combination of individual and group supervision monthly and reduction of the oversight to licensed, graduate level staff.

3. Unknown costs associated with training and no set process with DHS on training procedures, curriculums, approval process, etc.

4. Administrative costs in creation of quality improvement activities

3. Effectuating these regulations in the middle of a budget year and possibly a short time frame of compliance within 90 days. How will providers operationalize these costs within existing budget structures?

4. Without changes to the service delivery portion of the regulations including staff qualifications, many providers will be unable to provide these services, and creating a loss of jobs for working families and local economies.

5. The reductions in services access can lead to children, youth and youth adults moving to more costly, higher levels of care, including out of home placement

In closing, we would be remiss if we did not recognize the time and efforts the Department, providers and work groups have dedicated to this endeavor. We support the IBHS regulatory

reform process as a structured and strategic approach to ensure fidelity, to reduce higher levels of care, and to create access to effective services for this population of youth and families. We believe the positive intent of this remains at the foundation of the IBHS regulatory reform in creating cost effective and sustainable programs within service models that meet the diverse needs of our children, youth, young adults and families. We remain committed to this partnership and the work to see the IBHS regulations fully meet these standards

CHAPTERS § 1155 and § 5240.
INTENSIVE BEHAVIORAL HEALTH SERVICES
QUESTIONS AND CONCERNS

§ 1155.31. General payment policy and § 5240.3 Provider eligibility.

- "...complies with Chapter 5240..."
    - Will agencies be expected to comply with the regulations within 90 days of promulgation or the effective date of adoption of the regulations? Are the promulgation date and effective date different dates?

    - Will agencies be expected to comply with all of the training, supervision and quality management protocols within 90 days?
        - Many agencies do not have the capability to meet these standards, especially in this short time frame, either financially or with the staff qualifications/ratio.
        - When will the Fee Schedule for IBHS be determined? Providers will need this information in order to determine whether or not they will move forward with licensure.
            - Without an immediate increase in the reimbursement rate, providers will not be able to sustain this dramatic increase in non-billable activities. Yet in the Preamble, the Department of Human Services stated that these costs won't be taken into consideration until *future* BH-MCO capitation rates are determined. (Preamble pages, 8, 9 and 19)
            - The elimination of the ISPT meeting equates to an inconsequential amount of savings, if any at all.
            - In addition, very small amounts of savings, if any at all, will be recognized with the ability to transfer staff trainings from one provider agency to another. An increasing amount of staff are leaving agencies to find higher paying jobs outside of the behavioral health field due to years of insufficient funding.

§ 1155.32. Payment conditions for individual services.

- Written Order – How will the order contain the necessary clinical information and measurable improvements without the information from the assessment?

- Currently, the Best Practice Evaluation contains all of the necessary clinical information that would be included in the IBHS written order and assessment. A licensed psychologist or psychiatrist is able to determine service recommendations and measurable improvements based on ALL of the information collected.
- The IBHS process (a written order without the assessment information or collection of the assessment information apart from the written order) does not appear to be the most clinically appropriate approach for a child, youth or young adult.
- Who will provide training to all of the licensed physicians (or their physician assistants) and the others listed to enable them to appropriately determine the amount, settings and measurable improvements needed for IBHS services?
- Who and when will 3rd party insurers be trained?

- Assessment – in the Preamble it states that the assessment must be done in the "home or community setting" (pg. 6), but does not state this in the IBHS regulations. It may be most appropriate for the family to have the assessment information at an agency. The Department should not disallow that setting.
- Will the BH MCO accept the general treatment plan prior to the completion of the ITP for payment approval

- Initiation of Services – payment will be made if there is an order and a treatment plan (not ITP) for up to 45 days (75 days for ABA services 1155.33).
  - Will there be a prior authorization process?
  - Who will determine if payment will be made? Agencies do not have the financial capability to provide services without assurance of payment being rendered for services provided.
  - A definition of "treatment plan" should be provided as the regulations only define the components of an "ITP", not "treatment plan". {Also, 5240.41 (6)}

§ 5240.3 Provider Eligibility
Clarification:

- How will the Compliance with the Regulation date impact the license date of a program?

- What remedy will be offered if a provider's current license expires before the effective date of the regulations.
  i.e. If a provider's license expires in December 1 2019 and the effective date is January 1, 2020

- How will licensing be effectuated with programs that have multiple licenses that expire at varying intervals throughout the calendar year

§ 5240.6. Restrictive procedures. {Also, § 5240.41. (12) (vi) }

- (8) At times it is necessary to limit an individual's access to food, drink or toilet when they are abusing access, as part of an ABA treatment plan or when the items are used to cause a danger to themselves or others.

- (f) Trained person shall observe and document every 10 minutes.
    - In some situations a "trained" individual is not available as staff are able to provide this service in the home and community settings. How can agencies provide for the well-being of a child, youth or young adult in these situations?

    - DHS has determined that a member of the treatment team could be considered "trained". (Preamble page 74) If a treatment team individual has not participated in the agency's training, how can that individual be considered as trained?

- (h) Treatment team notification within 24 hours
    - Who is considered to be a part of the treatment team? Teacher, BH-MCO, prescriber, etc.?

    - It's unreasonable, and possibly unnecessary, to require that ALL of the treatment team members can be notified in 24 hours. It *would be* reasonable to expect that the parent/guardian and staff supervisor would be contacted within 24 hours of a manual restraint.

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- (2) (i) An IBHS Agency shall document the use of a manual restraint in the child's, youths or young adults' individual records in accordance with § 5240.41(a) (12)

  Clarification:
  In the event the incident report summary included the names or initials of other child, youth or young adults it could present a violation of confidentiality to place this in the individual records

  Request: Could a separate file be maintained for critical incidents/ use of manual restraints?

§ 5240.7. Coordination of services.

- (e) Written referral process and documentation of referrals for children whose needs cannot be served by the agency.
    - Clarification is needed as to whether this refers to families *seeking services* for their child's needs and/or children, youth and young adults in services with a *current authorization* that cannot be filled or have needs beyond those that the agency can provide for.

§ 5240.11. Staff requirements.

- (b)(2) Agencies should be required to ***attempt*** to accommodate parents', legal guardians or caregiver's ***typical*** schedules.

  It is not always possible to provide services at times or locations beyond staffing capabilities or with a short amount of notification of change.

  Language change consideration:
- Insert "typical schedule" as scheduled change daily based upon operational values in a given day
- Insert "attempts to accommodate" it is unreasonable to schedule every child's visit around every parents schedule

- (e) In order to have the sufficient number of staff to comply with *increased* administrative oversight, clinical supervision and monitoring requirements, a reimbursement rate would need to be adequate to cover these costs. Provider agencies will not be able to comply with or be licensed in IBHS without appropriate compensation to cover the costs of all of these activities.

- (f) An IBHS agency must employ a sufficient number of staff to provide the maximum number of service hours identified in the written order and the ITP.
  - Due to the current staffing crisis caused in part by the low reimbursement rates, agencies will not be able to comply with this component of the regulation.
  - What will happen to agencies that are not able to fully staff the ***maximum*** number of service hours?
  - It is stated in other places that the ITP can recommend fewer hours and a new order is not needed. Will the provider still need to have staffing adequate to meet the ***maximum*** hours in the written order?
  - These requirements, and others like them, throughout these regulations, can be taken to extreme by a BH-MCO in a value-based payment arrangement to cause an already ill-funded system to collapse.
  - In the event an agency has specific staff for Quality insurance, can this be delegated to that staff person?

§ 5240.13. Staff training plan.

- (3) The agency training plan should be based on service outcomes and staff performance evaluations.
  - As service outcomes are individualized to each child and staff performance and training plan needs are specific to each staff, what does the Department mean by an annual review and update of the agency training plan?

Clarification:
Is there an expectation that every employee individual training plan is reviewed annually? For large agencies this could entail significant time and personnel costs

- (7) {Also § 5240.73, § 5240.83, § 5240.93} What will the process be to approve all of the necessary trainings that agencies will require in a timely fashion? The Department has already stated a cost of over $400,000 to appropriately license agencies. Has the Department stated the cost of additional staff to approve trainings?

- Department Approval of Training
  Clarification:
  Will there be a list of already approved trainings?
  Will the training approval process be fully functional at the effective dates of the regulations?
  What is the process for training curriculum submission for approval?
  What is the expected time frame for review and approval?
  During the review period what are the options for an IBHS agency to bring in new staff
  Are E- platform program such as RELIAS, accepted as an approved training?
  Will CEU's be accepted as training credit
  How is the Department equating the new training requirements as being neutral in cost to an IBHS agency?
  Will the Department create a mandatory initial training curriculum?
  Will the MCO accept these training plans?

§ 5240.21. Assessment. {Also § 5240.85, § 5240.95}

- (5) and (f)(2)...child has not made significant progress in 90 days from initiation.
  - What is considered "significant"?
  - Who makes that determination?
  - As the assessment contains primarily biopsychosocial information, why would an updated assessment be required each time the ITP is updated in accordance with the regulations?
  - Request:
    Instead of re assessing, can new targets, goals and treatment strategies be updated through the ITP process. A process that provides solution-based strategies to the conditions noted

§ 5240.22. Individual treatment plan. {Also, § 5240.86, § 5240.96}

- (6) Settings where services may be provided.
- (7) Number of hours of service at each setting.
  - Stakeholders, including families, had expressed the need for flexibility in service provision. These requirements are more restrictive and are not client-centered.
  - Language change Request:
    Hours and service delivery at specific settings can be adjusted to best meet the needs of the child, youth, young adult, parent, guardian or

caregiver

§ 5240.61. Quality improvement requirements.

- Annual Review - (iii) Assessment of the outcomes of services delivered and if ITP goals have been completed.
    - Wouldn't this be specific to each individual child not the agency?
    - Will this be done for each child in the Annual Review or will a sample of individual records be sufficient?
        - (2)(i) Seems to indicate that a sample would be sufficient. There appears to be contradictions in other portions of the regulations at
        - § 5240.41(b)(3) and § 5240.11 (d)(4)

§ 5240.41 Individual records

(a) (12) Documentation of Manual Restraint in Individual File

- Clarification
  In the event the incident report summary included the names or initials of other child, youth or young adults it could present a violation of confidentiality to place this in the individual records

  Request: Could a separate file be maintained for critical incidents/ use of manual restraints?

(b) (3) Reviewed quality by the Administrative Director, Clinical Director or designated quality improvement staff within 6 months of the initial entry. After initial review, subsequent reviews may be limited to new additions to the record and must occur at least annually.

- Clarification:
  The interpretation that every single record in an organization to be reviewed. Can reviews be a sample size, as it may not be realistic for larger organizations?

§ 5240.71. Staff qualifications for individual services.

- Comment:

  The Department and Statewide work group went to great lengths to determine the modality of service milieu's for IBHS including; (non-ABA) individual Services, ABA

Services and group services. It can also be inferred that the creation of separate services was also an effort to insure the high fidelity of ABA services as well as a settlement response to the Sonny O litigation

In (5) (b) Individuals who provide behavioral consultation services for children diagnosed with ASD for the treatment of ASD shall meet the qualifications for an individual who provides behavior analytic services or behavior consultation ABA services in § 5240.81 (d) or € (relating to staff qualifications for ABA services) ABA

It is understood the need for the strict adherence to educational and experiential requirements for the delivery of ABA, but why a Behavior Specialist who is providing another intervention in individual services be required to have the ABA qualifications There is a specific section of the regulation that outline the qualifications for those identified staff delivering ABA services.

Additionally, it is accepted, in accordance with Act 62, that a license is needed to serve individuals with ASD; it is not necessary for them to be trained as or under BCBAs because they are not delivering ABA in Individual Services.

These requirements essentially undermine the strategy of creating both individual services and ABA Services and t creates a perceived shift to all IBHS services delivered in an ABA platform

An example, a child with ADHD will be able to access individual services readily, as there are many professionals indicated as able to treat this individual. However, if a child with ASD tries to access the very same services they will not be able to readily access these services because their clinician will need education and experience way beyond the clinician who is serving the client with ADHD.

This practice could be construed as discriminatory on restricting access to individual services (Non ABA) to consumers with Autism.

- Behavior Consultation Services
    - (b) Individuals who provide behavior consultation services to children diagnosed with ASD must meet the additional training requirements or experience in ABA even though the Individual Services section does not apply to ABA. This requirement will decrease treatment access to children with ASD who ARE NOT seeking ABA services. This requirement should be removed from the Individual Services section and be replaced with the ACT 62 requirement of licensure.

- BHT – Behavior Health Technician (by January 1, 2021)
    - The certifications required are all based on ABA even though this section applies to Individual Services. Therefore, the Department is mandating training and certification in a specific treatment modality.

    - (5) 40-hour training covering the RBT List – certification – BCBA or BCaBA as trainer {Also 5240.81 (5)}
        - During stakeholder discussions, access to services was stressed. Certifications that require a BCBA as a trainer and supervisor are going to limit access and are not necessary in the Individual Services section. As this service is NOT listed under the ABA services, ABA certifications should not be a requirement for a BHT.
        - Recommendation: the 40-hour training covering the RBT Task List is available through many venues including on-line training platforms. Individuals with a high school diploma who have successfully completed the 40 hours of training should be qualified for hire as a BHT. Instead, this section should read "completion certificate(s)" of the 40-hour training covering the RBT Task List and should <u>not</u> require a trainer who is a BCBA or BCaBA. This is inferred in the preamble on page 18 but stated very differently in the regulations.

    - (6) Have a minimum of 2 years of experience in the provision of behavioral health services.
        - While this may allow for a transition of current Therapeutic Staff Support workers, access will become an immediate issue for <u>all</u> children, not just ASD. It will be extremely difficult to hire new BHT staff that have one of the five certifications listed.

- Request for Proposed change:
  For the purpose of staff qualifications for the provision of individual services note that each of the certificates listed below independently meet the degree, practicum and internship requirements and should stand alone as a qualification to provide individual services under the IBHS regulations.
  - LCSW
  - LPC
  - LMFT

§ 5240.72. Supervision of staff who provide individual services. {Also 5240.82, 5240.92}

- Supervision of BC and MT
    - (1) and (2) - One hour of individual supervision per month plus an additional one hour of supervision if supervisor of BHT services.
        - This is an excessive amount of supervision for graduate-level and/or licensed individuals.
    - (3) Mobile therapists should not have direct observation of services being provided during therapy sessions.

- The increased amount of Supervision provided ***individually*** to individuals who provide behavior consultation services and mobile therapy services will dramatically increase the costs to providers.

- Supervision of BHT
  - (1) Each full-time BHT will require one hour of individual supervision that includes only the supervisor and the BHT. This ***individual*** supervision should be required monthly (as in past BHRS bulletins). Weekly supervision should be allowed as group supervision as outlined in 5240.72. (4)(d). This increased amount of ***individual*** supervision will dramatically increase the costs to providers.

- (4)(d) Group supervision? When will Group Supervision meet supervision requirements in the regulation as most require *only* the individual and the supervisor? Clarification from the Department is required.

- Clarification

  What requirements of the regulations can be met through the group supervision process?

  Onsite Supervision of a mobile therapist; having an observer in an individual session could be crossing an ethical boundary negative client reaction

  Does "Go to Meeting" web meeting application qualify as a secure transmission

  Supervision levels for positions are excessive and more reflective if supervision standards for practicum level or pre license experience

§ 5240.75. Individual services provision.

- (a) Behavior consultation services – assistance with crisis stabilization should be included in this provision as well as in the Mobile Therapist description. Not all children will require 2 graduate level professionals; the Behavior Consultant should be able to assist in crisis stabilization if needed.

§ 5240.81. Staff qualifications for ABA services.

- Clinical Director – ABA – BHRS providers have expressed the concern that this requirement may be impossible to staff. There is a limited amount of BCBA's in the state and psychologists may not see the necessity to get additional credits or training to act in a supervisory role.

§ 5240.111. Waivers.

- Are waivers for specific requirements within these regulations or can a program or program components be considered for a Waiver? (i.e. Program Exceptions in the past.)