Vista

August 9, 2019

Independent Regulatory Review Commission

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

To Whom It May Concern:

Please accept the following submission as the official comments from Vista Autism Services, an educational and behavioral health organization located in Hershey, PA. Vista, among other things, has a 17 year history of providing intensive, educationally integrated ABA treatment for children, youth, and young adults with Autism Spectrum Disorder, and as of August 1st, these programs are serving over 120 individuals. Our programs have validated outcomes showing the success of our model. Under the proposed regulations, our model, and clients, are at risk.

In general, we applaud the Department for taking on a needed and long-awaited project – the regulation of and improvement in "Behavioral Health Rehabilitation Services" system. This endeavor is not easy or to be taken lightly. We respect the individuals involved who took on this important work. Since providing feedback in September of 2018, there appear to be some changes in the proposed regulations.

However, there continue to be serious flaws as well as unreasonable requirements and unfunded mandates that will burden agencies financially; in many places the regulations place these burdens on providers unnecessarily.

The current draft:

(1) Unnecessarily and excessively adds onerous administrative and supervisory procedures on the providers that do not support quality outcomes,
(2) Lists numerous unfunded mandates that will increase costs to providers,
(3) Dictates unnecessary and illogical administrative processes, paperwork, and systems that will not result in improved quality but by contrary, will take time, attention, and money away from direct client care, and
(4) Does not sufficiently address core issues with quality (e.g., lowering quality standards for professional positions).

Our analysis shows that Vista will incur over $800,000.00 in additional unreimbursed annual costs as a result of these regulations. The largest "IBHS" program run by Vista was budgeted to have a 1.9% operating margin for 2019-2020 FY. With the added costs above, and no rate relief or cost negotiation process proposed by the Department, these regulations will essentially bankrupt this program. The Department has not provided sufficient evidence that many of the detailed requirements lead to improved outcomes for individuals served; nor has the Department made it known how the increased provider costs will be addressed in order to avoid program shut-down. *Vista, therefore, opposes these regulations in their current form. If they are updated to address the issues highlighted, Vista could support them.*

Specific comments related to the regulations are as followings:

1. § 1155.33 Payment Conditions for Services: ***Clarity, Reasonableness of Requirement***

   - **Add Treatment Plan to the definitions** section as the term is used, but not defined. How is it different from ITP?
   - The intent of the treatment plan appears to be a general plan to start services prior to an agency having enough information to draft an ITP. **The term should be defined to protect its intended use.**
   - (a)(iv) Orders for ABA services from a physician/prescriber will not yet have the detail that is listed in this section. **The subsequent completed assessment, following the receipt of the written order, should produce information such as the hours, the measurable improvements expected, etc.**
     - **Remove (C) and (D) from being included in the written order.**
   - The assessment should be permitted to occur **in any location** where the clinician feels is most appropriate to gather information relevant to the presenting issues.

2. § 1155.36 Covered Services: ***Clarity***

   - Waiver process is not explained. **Are waivers available for any portion of the regulation?** What is the process for obtaining a waiver?
   - In the preamble (pg. 65), waivers are eluded to as a mechanism for which to use when a requirement 'cannot' be met. However, due to the specific and detailed nature of many of the regulations, there simply may be *another way* to meet the intent of the regulation. **Will waivers be granted to providers with different methods for achieving the outcomes of IBHS, provided health and safety of clients is not compromised?**
   - **How will waivers be made available within the 90 day compliance window?**

3. § 5240.3 – Provider Eligibility ***Clarity and Reasonableness of Requirement***

   - The department **does not explain what 'comply' with the regulations means** as opposed to obtaining a license under the regulations. Does an agency, already licensed to provide BHRS exception services, have until their licensed renewal date to determine how to best integrate IBHS regulations into their practice (or obtain a waiver)? Or must they arbitrarily expense hundreds of (wo)man hours and tens of thousands of dollars to comply with regulations within 90 days – regardless of when their licensing visit will be and what waivers they may apply for?
   - The Department is asked to **update a reasonable time frame for compliance to regulations** (e.g., likely greater than 90 days) and provide evidence that compliance is possible if the timeframe is less than 180 days.
   - If a provider's license expires prior to the 'compliance date' what guidance will the Department give?
   - If a provider has more than one BH Exception program, **will they have to obtain more than one license?** What if each program has its own Service Description and unique waivers associated with it?

4. § 5240.4 – Organizational Structure *Clarity* and *Reasonableness of Requirement*

- **Please specify the exact detail, or extent to which a relevant change to organization structure requires Department notification with 30 days.** Please provide rationale for the Department to know of *every change to an agency's organization chart/structure* (e.g., a new secretary is added to the organization, a supervisor changes to oversee a new person, the facility manager now reports to the Infrastructure Director...etc.).
  - The annual cost estimate to monitor for changes and update the State is $268.00

5. § 5240.5 – Service Description *Fiscal Impact*

- The estimated cost to update an existing and approved service description document to meet these regulations is $4,349.90

6. § 5240.6 Restrictive Procedures *Protection of Public Health, Safety and Welfare*

- The misuse and abuse of restrictive procedures with a vulnerable population is intolerable and represents a violation of their human rights and is unethical. However, improper conduct must be separated from and differentiated from the safe and effective use of restricted procedures as components of carefully considered, properly implemented comprehensive ITP for dangerous, injurious, and destructive behaviors – that left untreated cause further harm for the person(s). **In this section, the prohibitions listed in (a)(8) (those that restrict to access to food, water, or toilet) may be a medically necessary and clinically appropriate for some individuals.** Restrictive procedures, when used as part of a carefully planned, professionally directed comprehensive intervention program and in accordance with recognized standards of professional practice can have life change positive outcomes for individuals whose behaviors are dangerous, destructive, or injurious. *To blanketly prohibit, in such broad terms, evidenced based procedures that have the ability to provide positive impact to the most disabled, when properly used, is a mistake.*
- The Department should, instead, **offer providers the vehicle** (e.g., a human rights team process) **for which it can use to approve and oversee the use of restrictive procedures when clinically indicated.**
- (f) **How does this bullet get satisfied when a staff is alone with a client?**
- (h) **Define (a core) treatment team for purposes of notification of a restraint.** This bullet, if read liberally, will dissuade agencies from using restraint procedures if the burden of notifying *everyone* on the broader treatment team (e.g., doctor, dentist, outpatient speech therapist, etc.) is required. Vista agrees with notifying key members within 24 hours, and does so as its practice; however, the list must be practical for it to be accomplished.
- (K) (L) (M) **Why is the term restraint replaced with restrictive procedure in these bullets?** They are drafted to read about manual restraint, yet the term restrictive procedure was inserted. There is exists no "test process to demonstrate the ability to properly apply the restrictive procedure." These terms should be replaced with *manual restraint*.
- **The Department is asked to communicate the process and timeline for approving training programs.** How will the providers be protected from the Department creating a

monopoly or duopoly, as has been the experience in other certification areas approved through the State (e.g., Customized Employment in OVR funded services)? This drives up costs and reduces access.

- Many agencies using an electronic health record may implement an incident management system within the platform. Will that satisfy that (i) the record of a child/youth include record of manual restraints?

7. § 5240.7 Coordination of Services — ***Clarity, Reasonableness of Requirement Unfunded Mandate***

- As the licensing department knows well, the requests for letters of 'coordination of care' often go unanswered. **As long as *attempts to secure these letters* by the IBHS agency are counted as meeting this part of the regulation, we have no comment.**
- The Department is asked to **clarify what they mean by coordination of care.**
- (e) The Department is asked to clarify and provide further detail as to **why an agency must maintain records for individuals it does not serve.** What is meant by "document the referrals made for a child the agency could not serve?" How long does an agency keep records for people who are not clients? What type of staff person is to perform these non-billable activities? What mechanism modulates the volume of work around this requirement and the unfunded burden to the agency? This requirement appears to place case management and care management responsibilities on providers for individuals who are not clients to that agency. **Under what authority can this mandated?**
  - The calculated costs for initially complying with this section are $4,799.20 with an annual ongoing cost of $1,426.95.

8. § 5240.11 Staff Requirements — ***Fiscal Impact, Need for Regulation, Reasonableness of Requirements, & Unfunded Mandate***

- **The regulatory mandate to have specific administrative positions is unreasonable, does not improve quality outcomes, and will drive up costs.** The Department is asked to provide evidence that such a mandate is a causal factor to quality outcomes for programs. During the comment period we asked the Department to list the specific areas required for accountability within an IBHS agency and to allow the agency to show the Department how and where those responsibilities where housed within their own agency. During the Stakeholder Workgroups it was mentioned these regulations were to promote flexibility across all agencies to meet the needs of the Commonwealth. Restrictive regulations such as mandating specific positions with specific reporting relationships (b)(6) is counter to their stated goal and should be removed.
- To the extent that an established agency has people and infrastructure to support the duties listed under "Administrative Director" the Department is asked provide guidance as to how an agency may document the completion of said duties (e.g., a Compliance Officer exists and is the person responsible for (b)(3); a Quality Director for (b)(5)).
- (e) Specific comments regarding the reasonableness of the supervision requirements and administrate tasks mandated in these regulations can be found elsewhere. Vista's total cost of the combined staffing to meet the supervision and onerous administrative requirements referenced in (e) amounts to $316,445.98 annually.

- (f) What does it mean **"shall employ a sufficient number of qualified staff to provide the maximum number of service hours identified in the written order?"** What if the maximum number of hours is not requested by the family? What if the hours are not regularly scheduled? Or are handled differently in an approved Service Description (e.g., coverage made available based upon behavioral need)?
    - This item alone adds $421,864.67 added costs, on an annual basis, to Vista's personnel budget as it is written.

9. § 5240.13 Staff Training Plan ***Reasonableness of Requirement, Fiscal impact***

- (a) **Mandating the specific use of '*individual training plans based upon education level, experience, current job function and performance reviews*' is unreasonable, cost-prohibitive, and is not linked to client outcomes.** Providers should be able to show that agency training plans (differentiated by job function), HR policies, and sound performance management programs will accomplish similar intention, at substantially less cost, and paperwork load.
- (a)(3) **Remove the mandate that agency training plans should be based upon evaluations of staff.** This is not a best practice in the training and performance evaluation fields (references available upon request) and takes a very narrow view of all the variables that effect a staff performance (e.g., competency of supervisory, saliency of immediate consequences for actions, available resources, robust feedback loops, etc.). The actions taken by providers to meet this requirement will be in vein and add unnecessary costs.
- (e)(2) Department should clarify what it means by "...person's qualifications to conduct the specific training." It is unreasonable to for a training record (meant to document an event) to document specific qualifications of the trainer for that specific training. Who is the authority determining who can train what (the provider, the Department)? What is the evaluation system to be used?
- (e)(5)(6) **Remove all statements (as written) related to the retention of training materials and handouts.** The requirements in these regulations related to keeping copies of every training version and every handout of every training ever delivered to a staff are costly, redundant, and overly-burdensome. **Instead, consider mandating a course syllabus be on file (paper or electronically) for each course that links to a *regulated training*.** Many agencies use Learning Management Systems (LMS) and would need to set up entirely separate and duplicative systems to uphold the regulations as written. Further, trainings are dynamic – updated with new knowledge and understandings of research frequently. As written, the regulations ask for every updated version to be approved by the department and kept – the storage and tracking alone is at least *1 new FTE* for Vista alone to uphold this sections of the regulations. **This type of mandate works directly against the introductory paragraph that indicated the updates to training would save the State and providers money.**
- (e)(7) **Provide further information about your intent (and process and timeline) to approve trainings.** Is this all trainings? What is the mechanism? Is this before they are delivered? What about when they are updated? Will the Department be hiring content experts to provide this approval? Does the department have instructional designers on staff? Will the Department provide technical assistance to providers who have trouble getting trainings approved? What about trainings in LMS systems that are designed by national context experts?

- The initial work estimate for rudimentary compliance to this section is $3,074.15 and the ongoing annual cost to maintain these standards is $17,920.66.

10. § 5240.32 Discharge Summary **Misalignment**

- Assistant Behavior Consultant – ABA is not able to complete a discharge summary, but can complete an assessment, per other sections of this regulation. The distinction is not logical. A discharge summary is not the highest order of clinical work, and could be completed at this level.

11. § 5240.41 Individual Records ***Clarity, Misalignment, Reasonableness of Requirement***

- (a)(12) Allow for the use of an **incident management module** within an online electronic medical records system. The record of a restraint may not be found in a client's physical file.
- (b)(3) This regulation **specifies that every piece of paper that goes into every clients' file is reviewed by the administrate director.** This is an unreasonable requirement, will drive up costs, and does not link to quality. Later in the regulations, § 5240.42 (2)(ii) it states a sample of records by the Quality Improvement department shall be selected for review. **These two regulations are in contrast, or duplicative.**

12. § 5240.42 Agency Records ***Reasonableness of Requirement***

- (a)(6) **Remove the mandate to keep a schedule of daily group services.** The mandate as written is excessive and overly restrictive to the agency. Keeping a sample schedule to meet the ITP goals is good enough for both monitoring and auditing purposes.
- (b)(2) **Remove the mandate of agency HR departments to track and store individual professional continuing education credits.** This is an individual responsibility of the professional. It is sufficient to have in the personnel record the most recent and valid License for each professional, NOT copies of all CEU's attended for each licensed individual in the agency. What is the benefit of regulation adding this additional work for HR departments?

13. **§ 5240.61 Quality Improvement** ***Fiscal Impact, Reasonableness of Requirement, Unfunded Mandate***

- Quality improvement requirements are brand new and while show great intention, do come with significant costs. **Please state specifically the mechanism for providers to build these costs into the rates as *allowable* or describe some other method for reimbursement.** As stated previously, the introductive paragraph proports that: "Costs to the department, local government, and individuals receiving IBHS are not anticipated." **How is that possible with mandates such as these?**
- (a)(2)(ii) is in conflict with § 5240.41 (b)(3).
- (b)(2)(c) The QI report made available to the public should not include the action steps to address findings. A general outcome report should be made public, but more detailed reports are for internal purposes. Specific data that is not de-identified that could compromise other systems or regulators should not be public.

14. § **5240.81 Staff Qualifications** ***Protection of Health & Safety, Unnecessary Confusion***

- (f)(3) **An individual with a Bachelor's degree, four classes in ABA and six months experience is NOT EQUIVELANT to a Licensed Behavior Specialist or a BCaBA** and this option should be eliminated from the experience options for the Assistant Behavior Consultation – ABA. This a dangerous lowering of qualifications and will likely result in harm to children. This person will also have no equivalency within Private Insurance, therefore be only a cost to the MA system.
- (g)(3) Eliminate the BCAT as an equivalent certification for BHT-ABA staff (to the RBT). The BCAT is an *Autism certification*, not an ABA certification. Therefore, it should not be used interchangeably with ABA qualifications for BHT-ABA.
- (g)(5) Update for clarity, that you intend for this bullet to read that the staff has a *certificate* (not certification) indicating they passed the 40-hour RBT course and competency exam (not actually become certified).
- The created titles for the regulations are confusing and difficult to map against national standards. The qualifications in general are not consistent. You can have a BCaBA at two levels; same for the LBS. When the qualifications are the same across two tiers of professionals, what distinguishes them? For example, how is the Behavior Consultation – ABA with a BCaBA different from an Assistant Behavior Consultation – ABA who also has a BCaBA?
- Will billing codes for each of these levels be created? How would new codes map to CPT codes? What is the Department's plan to adopt or adapt to the ABA CPT codes? (e.g., 97151, 97153…)
- If an RBT is certified, does competing the annual exam count as training or supervision time, or both?
- (g)(5) Can this 40 hours of training be completed within the first four months of hire? If not, agencies will be asked to train individuals for 40 hours (in addition to the training requirements in these regulations) prior to them providing any billable services. This is cost prohibitive and will render the intent of introducing HS graduates as a workforce moot. The cost of this requirement increases with an agency's turnover percentage.
    - For one staff, 40 hours of trainings would cost $674.80 in comp/benefits alone, (compounded also by the trainer costs). For an agency with 100 employees that experiences 35% turnover, it would spend $23,618.00 annually in pre-service training costs (salary only) for employees who leave.

15. § **5240.82 Supervision** ***Fiscal Impact, Need for the Regulation, Reasonableness of Requirements, Unfunded Mandate***

- **In general the regulations mandate supervision levels as if every professional and paraprofessional employee, regardless of tenure were still within their internship/practicum year.** The specific level of monthly supervision (documented and counter signed) is at levels unnecessary once professionals become proficient and competent – typically following a few years in practice. Further, individual supervision is only *one means* to obtaining quality services and outcomes for children – yet the reliance on overly burdensome levels of supervision within these regulations would lead one to

believe that individual supervision is the ONLY way to obtain quality outcomes. **The supervision mandated in the regulations must be completely overhauled. It is restrictive, costly, and represents 'form over function.'**

- If Vista were to implement the supervision regulations as written, it adds an estimated $316,330.45 to Vista's budget, annually.
- These supervision regulations negate that any other activity that may occur between a professional and another team member, trainer, supervisor, or consultant has an additive benefit to their clinical repertoire and the client outcomes. They also discount the cumulative effects of interactions that occur across a day or week that are unplanned, via email or other mediums (e.g., document, plan review) that constitute supervision activities in the professional realm. **How can an agency be allowed to continue other supervision activities (non face- to-face dyad meetings) that add to quality outcomes without being penalized? Supervision occurs in many more places and ways than just 'a one hour face to face meeting.'**
- Is it possible for regulations to hold an agency accountable for measurable client outcomes and not 100s and 100s of hours of supervision that have no discernable link to improvements for clients?
- **Remove the mandate for a 'narrative, countersigned' supervision note for all supervision sessions at all levels.** Allow agencies to develop documentation practices that work for them, to meet the requirement. This level of mandated detailed paperwork is unnecessary, overly restrictive, and does not have data to support its impact on quality. The dated signatures indicates a paper-based system which will add strain to an already very lean system.
    - The mandating of such supervision universally for every professional regardless of experience and competency is overly simplistic and restrictive to the agency.
        - This level of mandate does not exist in other licensed professions or sets of regulation
- (b)(1) Often, supervision activities occur with clients present so that relevant information and feedback are accessible, actions prohibited by these IBHS regulations. This regulation is unnecessarily restrictive and actually counter to Private Insurance billing codes.
- (b)(2) **As written, this more aptly constitutes training, not supervision, and this position has to have had at least six months prior experience in ABA (at the lowest experience level).** With this prior experience, what is the need for this additional pre-service training/supervision? What is to be delivered by a supervisor versus a trainer, and why is the Department mandating that distinction? Why is this needed when the position either has an LBS, BCaBA, or six months experience in ABA? Lastly, do these six hours count towards the 20 hours of pre-service training?
- (c) We would ask the Department to explain the following discrepancy: why a Licensed Behavior Specialist and the "non-certified Bachelor's Level" Assistant Behavior Consultant – ABA are equivalent for purposes of (1) holding the same job title and (2) completing the same job duties as listed in § 5240.87 (c) but are NOT EQUIVELANT when it comes to their perceived competency to provide supervision as listed under § 5240.82 (c). Why is this distinction made? The resulting confusion and staffing difficulties will add costs. We would suggest again, eliminating a non-certified Bachelor's Level Assistant.
- (d) Is group supervision allowable for all levels of ABA services? What requirements are satisfied using a group session? If we cannot satisfy any supervision with groups, we would ask the Department to explain the rationale behind the restriction. This is a common practice in the field, as is peer supervision.

- (b)(4)(iii) What does supervision of a BHT look like regarding considerations of adjustments to the ITP? Why are we being regulated to supervise someone on something that is outside their professional scope of competency? **Remove this bullet.**
- (e) **Remove the unreasonable and inflexible restriction of how many staff may be supervised by any other staff. The Department is asked to explain what data support this restriction?** How does a one-size fits all model support the outcomes and intent of these regulations? Further, this restriction does not acknowledge the common practice of separating clinical from administrative supervision.

16. § 5240.83 Staff Training Requirements ***Protection of Health, Safety & Welfare Reasonableness of Requirements***

- (e) and (f) state that continuing education to meet an individuals' certification and licensure status may count towards training requirements under (b) to (d). The intent to save money is clear; however, **this is essentially a loophole that allows people with non-ABA degrees or certifications to continue to perpetually avoid ABA trainings.** For example, a Licensed Nurse taking credits to maintain her certification as nurse, can substitute those credits for the mandated 20 hours of per service ABA training required in bullet (c)(1) (specifically meant for people without an ABA certification) and the 16 hours of annual ABA training required in (b)(2).
- (d)(1) Depending on the design of an agency's service description, some of the trainings listed in the individual services list may not be relevant. **Will the Department work with providers to allow specific agency training plans in order to avoid costly trainings that do not add value to the service being provided?**
- The initial costs to comply with the annual individual training requirements for BHT are estimated at $33,007.

17. § 5240.85 – Assessment ***Need for Regulations, Reasonableness of Requirement***

- (e) Please update the language to be "update relevant sections of the assessment, as needed, when." Many portions of the assessment are historical and will not be updated based upon the issues listed.
- (e)(6) **Please remove that the assessment should be updated with every crisis event, or distinguish between *types* of crisis events.** Do you mean that after every time a youth has a crisis (exhibits dangerous behaviors), or is possibly restrained, that the entire assessment must be updated?
    - This will cost Vista an estimated $56,890 in added staff costs PER YEAR due to the number of crises events over the last 12 months.
- (e)(5) When the client has not made significant progress, the professional or team *must do something* to find out why the client is not making progress (e.g., observe the child, implement fidelity checks, take different data, etc.), however, updating the assessment is excessive and won't solve the actual problem. Regulating something that is an act of clinical judgment is overreaching and should be changed. If not, will cause unnecessary work by treatment team members to fulfill the requirement, and add costs to the system.

18. § 5240.86 – Individual Treatment Plan

- (d)(2) **What are "intermediate" goals, as opposed to long term and short term goals?** This is not a term defined anywhere, or used in the field.
- (d)(8) **Please add the work "estimated" to the number of hours for each service location within the ITP so that this listing of hours does not become a reason to deny services or otherwise become a problem for families.** Hours should be flexible to more to the most relevant places for care.
- (g) **Please add "visual display of progress" as part of ITP updates.** Visual display of data is a hallmark to ABA and belongs in this section. It was noted in the preamble that this suggestion was dismissed. At minimum, goals and performance information should be listed in quantifiable terms.

19. § 5240.87 – ABA Services Provisions ***Clarity, Reasonableness of Requirement***

- (b) By stating that "behavior analytic services include functional analysis" **you have limited the conducting of Functional Behavior Assessments (FBA) to individuals with a license and a BCBA** (e.g., those qualified to deliver Behavior Analytic Services). Is that your intent? **This will limit access to FBA, and minimize their use in the assessment of ABA services** in section § 5240.85 – where you list the assessment may also be completed by a Behavior Consultant – ABA. Is this distinction deliberate? This will increase costs to providers to have a BCBA conduct all FBA, when other levels of professionals can be effectively trained to participate in portions of these assessment procedures.

---End comments---

Thank you for the opportunity to review and provide feedback to the IRRC.

In their current form, Vista does not support the promulgation of these regulations. We do sincerely believe that the substantive issues within them can be remedied.

Respectfully,

Kirsten K. L. Yurich, MA, BCBA, LBS
Chief Executive Officer

1021 Springboard Drive
Hershey, PA 17033
(ph) 717.583.5102 x2008
(fax) 717.500.2918
www.vistaautismservices.org