14-546-41 3209

Champa, Heidi

From:	Steven Kossor <sakossor@ibc-pa.org>
Sent:	Wednesday, August 22, 2018 10:55 PM
To:	Pride, Tara
Subject:	Responses to IRRC #3209 - Proposed IBHS Regulations
Attachments:	Response to IRRC Number 3209 sk 082218 signed.pdf; Additional Responses to IRRC Number 3209 sk 082218 signed.pdf

Please enter these responses into the collection of public comment regarding the proposed IBHS regulations.
Thanks.
Steve

3209

TO: Tara Pride **DATE:** 8/22/2018

FROM: Steven Kossor

RE: IRRC Number 3209 Proposed Rulemaking: **Intensive Behavioral Health Services (IBHS)**

Background

I am a licensed psychologist and certified school psychologist who has been practicing in Pennsylvania since 1977 (41 years). Throughout my professional career, I have worked with children and youth diagnosed with Autism spectrum disorders, ADHD and other conditions who have responded well to behavioral treatment using the principles of "Applied Behavior Analysis" that I and staff under my scope of practice have been delivering. I was one of the first three psychologists in Pennsylvania to enroll in the Medical Assistance program as a Behavioral Health Rehabilitation Services (BHRS) provider, in 1992.

In 1981, I began using the methodology that came to be called BHRS in Pennsylvania. That is more than 10 years before BHRS was formally created here, so I have considerably more professional experience as a provider of BHRS than anyone in the State. Over the past 30 years, I have been conscientiously improving my BHRS model and have been invited to present it as an evidence-based practice in conferences throughout the US since 2007. I have been presenting my work at the annual PA Early Childhood Education Summit and at the PA Head Start Association annual meeting for several years.

The BHRS model I developed combines Full-Fidelity Wraparound practices with Applied Behavior Analysis principles and employs dozens of "evidence based kernels" (Embry & Biglan, 2008), so it is clearly an "evidence-based" model of behavioral treatment for children. Independent researchers from four different educational institutions (University of North Carolina at Chapel Hill, Thomas Jefferson University, Villanova University and Immaculata University) have studied the treatment outcome data that has been collected for more than 10 years and all found statistically significant reductions in violence with improvement in environmental safety, communication and socialization skills in as little as four months, with sustained improvement for at least one year. Ninety percent of the children and youth I have treated over the past 30 years have completed the BHRS program in three years or less. I have written two books documenting the successful behavioral treatment of children with Autism, ADHD and other conditions in their homes and communities using my BHRS treatment model with funding provided by the Medicaid EPSDT program. I have testified in Federal court as an expert witness regarding Medicaid EPSDT funding.

In 2011 and again in 2018, I received commendations from the US Congress in recognition of my creation of a cost-effective means of providing professional mental health treatment to children enrolled in Medicaid in their homes and schools. Both houses of the PA legislature have also commended me for this work, and I received a commendation from the Centers for Medicare and Medicaid Services (CMS) for the model of BHRS delivery that I created that responsibly utilizes Medicaid funds. I was invited to the White House to be recognized as a Champion of Change for Community Based Children's Mental Health; among the honorees was the current President of the American Psychological Association, Arthur Evans.

References

Embry, D & Biglan, A. (2008). Evidence-based kernels: Fundamental units of behavioral influence. Clinical Child Family Psychology Review. Sep; 11(3): 75–113.

Kossor, Steven (2016) The Issachar Project. NSP Press.

Kossor, Steven (2018) The Kossor Scale for Treatment Outcome Measurement. NSP Press.

The Department of Human Services deserves commendation for its efforts to manage the lobbying efforts of representatives of the Florida based *Behavior Analyst Certification Board* which has been agitating for benefits to holders of their certifications in licensing and other regulations throughout the US for years. Emerging professions all struggle to portray their own oracle as the voice of truth in a sea of confusion, and the BCBA/ABA group is no different, but their efforts to malign the skills and abilities of existing qualified practitioners of psychological methods (including ABA and BHRS) are both inappropriate and misguided. The IBHS Workgroup was incommoded by efforts of BCBA/ABA lobbyists throughout its existence according to informed sources within the DHS, and some of the language in the proposed IBHS regulations bears the imprint of their pressure. Some of these lobbyists are actually criticizing the proposed IBHS regulations as *lowering* standards when, in fact, the proposed IBHS regulations are unequivocally *raising* the standards above those of the BHRS program it will be replacing. The BCBA/ABA lobbyists reveal their actual agenda (promoting themselves and their niche) by lamenting the so-called lowering of standards below those to which they would like all other practitioners to aspire. Their standards are rather like driving a tack with a bazooka: 270 hours of graduate level training for a BCBA vs. 90 hours of training for a BSC license, for example. While the BCBA/ABA lobby has stridently reported examples of parents and children who have been harmed by the misconduct of non BCBA/ABA providers, there are also parents who describe horror stories of mistreatment by BCBA/ABA practitioners (some of whom have been found guilty of Medicaid fraud and barred from billing Medicaid ever again).

It is certainly true that heinous abuses have been perpetrated throughout history by self-proclaimed experts who have preyed upon the naivety and good will of unsuspecting victims. That is why regulations are important. However, it is a cruel injustice to paint licensed psychologists with decades of successful experience in the field of behavioral treatment of children with that awful brush of "charlatan," or to exclude them from the planning for the development of the IBHS system. Yet this has happened, and the proposed IBHS regulations have suffered because of it. The proposed IBHS regulations have been bent too far in the direction preferred by the BCBA/ABA lobbyists. The proposed IBHS regulations do not accurately reflect the benefits that professional psychologists have had in the BHRS world. Benefits that psychologists should continue to provide ought to be acknowledged and allowed in the IBHS regulations.

Although I am a licensed psychologist, I have not sought or received certification from the Behavior Analyst Certification Board and I don't have a Doctoral degree. For some people, these are impassible obstacles to the delivery of competent and successful treatment of children, especially those with Autism spectrum disorders. Yet I *have* been very successful for 30 years (as measured by the numerous reports of parents whose children's lives were changed for the better, and the treatment outcome data that has been collected weekly for more than 10 years). Professionals who have reviewed my work realize that it is a testament to the value of simply applying the principles of learning and motivation to the task of helping children achieve higher levels of functioning within the context of a therapeutic relationship. I practice humanistic behavioral psychology, not manualized *"Behavior Modification mit a German Accent."*

The children I've helped over the past 30 years would not have made nearly as much progress if they had been treated by expert manual-readers applying their short list of interventions exactly as their trainers told them to, and reducing a child's functioning to the alphabet blocks of A (antecedent), B (behavior) and C (consequence) as the height of excellence that many in the BCBA/ABA lobby aspire to. Children need help from adults who understand that they have **skill deficits** which lead them to display immature, maladaptive responses to everyday challenges. By helping children to acquire missing skills, their inappropriate behavior naturally diminishes. This is the model that Stanley Greenspan endorsed. He eschewed "certification" as a measure of competence and resisted it to the day he died. Credentials doth not competence make, but standards of practice need to be maintained at a high level and there is no substitute for the professional **peer review** of treatment documentation to uphold that standard.

When a professional assesses a child from physical, developmental and behavioral perspectives and oversees a treatment program that addresses skill deficits through a therapeutic relationship with a client, they are practicing psychology as it should be practiced, and clients get better. Not "cured" necessarily, although that happens too from time to time. They are better able to manage the challenges they'll face for the rest of their lives than they would have been if they had never met and experienced the encouragement of someone who cared deeply about them – a treatment provider who tried to "see things the way they do" and offered developmentally appropriate and persistent encouragement to see things differently. By keeping a weekly record of progress in a sensible, defensible way, practitioners of psychology (whether they possess BCBA or ABA credentials or not), are delivering a "covered service" under the EPSDT mandate of the Medicaid Act and should be permitted to deliver these treatment services in Pennsylvania – not *excluded*, for obscure reasons, as the proposed IBHS regulations stipulate.

Recommendations

1. It should not be necessary for a licensed professional psychologist with a documented track record of successful implementation of BHRS/IBHS to children with Autism spectrum disorders to be supervised by someone just because they have a BCBA credential. If the psychologist believes that he/she could benefit from an ongoing collaboration with someone with a BCBA credential, as I do, then that consultative relationship should be *encouraged*, but not required, in the IBHS regulations. Collaboration without coercion is the goal of responsible professionals. I have been receiving supervision from a highly skilled ABA practitioner with BCBA certification for more than a year to assure the maintenance of my own understanding of modern ABA standards; it has been a rewarding experience for both of us and we expect it to continue.

   A. The criteria for documenting the "successful implementation of BHRS to children with Autism spectrum disorders" should be specified in the proposed IBHS regulations. I suggest that an experience criterion should be set at no less than 10 years. Prior to the 10th year of experience as a successful provider of BHRS/IBHS treatment, collaboration with a psychologist having the minimum 10 years of successful experience, or collaboration with a BCBA credential holder with comparable successful experience in delivering and monitoring BHRS/IBHS, should be required.

   B. The criteria for documenting the *successful* implementation of BHRS should include references from at least five families who report having received successful treatment services under the scope of practice of the licensed psychologist, and a description of the benefits that were received. The description of benefits should address the foci of Applied Behavior Analysis: that improvements were made in areas of social significance, that the improvements were statistically significant based on a standardized data collection process, and that the treatment process included input from the child, parent(s) and other adult caretakers at no less than weekly intervals.

2. The IBHS regulations should reaffirm that the Medical Necessity Criteria (MNC) established in PA regulations at **§ 1101.21 (a)** are to be used by Behavioral Health Managed Care Organization reviewers of IBHS treatment prescriptions to determine whether or not a prescription for IBHS is "medically necessary." The MNC were adopted in 1992 and published again in the PA Bulletin on April 21, 2007 on page 1880. They have been widely ignored ever since by BH-MCOs throughout the State.

   In August of 2009, following my testimony in Federal court, DPW (DHS) issued a requirement that all BH-MCOs must incorporate language regarding use of the MNC published at **§ 1101.21 (a)** in all BHRS provider Agreements throughout their respective networks. Despite this directive from DPW/DHS, and their dutiful incorporation of the words, BH-MCOs have cleverly devised a variety of schemes over

the years through which a child's Civil Right to Medicaid EPSDT funding has been thwarted, sometimes with the active support of DHS authorities, unfortunately. That led to the filing of two Civil Rights complaints that took three years to investigate and led to some unpleasant outcomes.

According to Federal and State law in in Pennsylvania for more than three decades, a child enrolled in Medicaid is entitled to EPSDT treatment funding for any one of three reasons: 1) to prevent the worsening of his/her disabling condition, or 2) to treat the condition, or 3) to maintain his/her functioning at a level comparable to that of similar aged peers. These are the "medical necessity" criteria referred to at ***§ 1101.21 (a)*** and the IBHS regulations would be enormously strengthened through a reference to them in support of their continued applicability to IBHS.

3. The National Academy of Sciences (2001) and the American Academy of Pediatrics (2007, 2012) have announced the results of their investigations into the treatment needs of children with Autism symptoms: a **minimum** of 25 hours per week of intensive, individualized treatment, year-round, is required in order for a child with Autism symptoms to have a reasonable probability of symptom reduction. TSS providers in the BHRS realm and Behavioral Health Technicians in the proposed IBHS regulations are providers of "intensive, individualized services." The unequivocal national standards of care, from unimpeachable authorities, should be respected by ethical professional practitioners everywhere. Nevertheless, the "standard" being created by Behavioral Health Managed Care Organizations throughout Pennsylvania is between 5 and 15 hours per week. Some of them have actually said that they will not authorize more than 20 hours of TSS service unless the child is violent and dangerous. That is outrageous; it violates DHS instructions issued in March of 2016 to curtail this excessively restrictive standard for TSS service, so the proposed IBHS regulations should require that prescriptions for IBHS should be compared with these national standards during the process of determining the "medical necessity" of the prescribed services. Otherwise, BH-MCOs will remain free to use their own occult standards to unfairly and inappropriately restrict access to utterly reasonable, "medically necessary" levels of care that meet modern national standards.

4. IBHS, like BHRS, cannot be sustained without a significant increase in the level of compensation paid to its providers. The BHRS system has been suffering from a lack of funding for **27 years**, during which time, no cost of living adjustment (COLA) has ever been made. Providers have existed on a progressively thinning margin, yet they persist because they know the children are getting better with their help. I have personally seen children leave the Autism spectrum because of the work performed by staff under my scope of practice. The late Stanley Greenspan, whose work to treat children with Autism is legendary, personally endorsed the efforts my staff made in the treatment of a patient we shared for three years; the child's parents reported that he said to them *"I don't know where your son would be without the work that Mr. Kossor's staff are doing."* Success should be rewarded, right?

5. It is clear that without an increase in funding for Behavior Specialist, Mobile Therapist, and Behavior Technician services (with or without appended "ABA" qualifiers), it will be exceedingly difficult to recruit sufficient numbers of IBHS providers to deliver these services. The need for qualified providers will only continue to increase, unfortunately, for all of the reasons that such developments occur, so it is imperative that the IBHS organizations are able to compensate IBHS providers at a living wage for the work they do. A cost-of-living increment process is needed in the IBHS regulations.

   In other states cited in the proposed IBHS regulations, the pay rates for services comparable to IBHS are between 45% and 100% higher than those paid in Pennsylvania – not surprising, since the cost of living has increased so dramatically throughout the US over the past 27 years.

6. A distinction needs to be made between the providers of **administrative support** and those who are responsible for the delivery of **clinical services**. The former (administrators) should be accountable for proper billing of services, recruitment and assignment of qualified staff, monitoring staff credentials including training and supervision receipt, and for implementing appropriate disciplinary measures in accordance with a written Compliance Plan. The clinicians should be responsible for overseeing the creation and amendment of treatment documents, including evaluation reports, treatment plans, plans of care and correspondence/communication with the parents and other caretakers of children receiving treatment, and for providing necessary supervision and oversight to the treatment delivery staff. The proposed IBHS regulations speak to this need with remarkable precision. However, to require an advanced professional degree (a Masters degree) for the **administrative** support personnel is excessive and unnecessary, provided that the division of responsibility for the two major arms of IBHS delivery is maintained, and accountability for each separate arm is vested in an appropriately credentialed person, and their performance is monitored.

7. A data collection standard should be established within the IBHS regulations that mandates the documentation of **weekly** assessment of progress, using a **criterion-referenced** measure, as is common practice in schools. For example, a teacher reliably assesses the progress of students in acquiring skills in the classroom by designing a measure of performance for the specific skills that are expected to be developed. The teacher administers brief assessments every week, and the results are recorded. In addition "norm referenced" tests are also administered annually in Pennsylvania.

   In the case of IBHS, a simple assessment can be administered to a parent asking them to report on the frequency and severity of the child's troublesome behavior. This would have the added benefit of facilitating greater communication between parents and schools. The scale used for this reporting needs to be specially designed so that it collects data that can be used in statistical analytic procedures to document whether the child has made significant progress over the course of treatment, based on repeated measures. Using this scale, the assessment process takes less than five minutes and produces reliable, valid data that can be analyzed with sophisticated statistical methods because it creates **interval** data (not just "questionnaire" data). I created this scale and have been invited to describe it at international meetings, including the Friends of Families for Children's Mental Health and the annual Expressive Therapies Summit in New York City; I would be pleased to share it with the IBHS workgroup. It's described in detail in my books. This data collection would supplement norm-referenced measures that are widely used, but which are not as sensitive the changes and provide little value over periods of time less than one year.

8. I am thankful that the proposed IBHS regulations include the following text on page 45 (page 18 of the document in which it is quoted): ***An IBHS agency can also use a model intervention that it has developed and that has been designated by the Department as a model intervention. This will provide IBHS agencies with the opportunity to expand the service array to meet the therapeutic needs of children, youth and young adults.***

   Although this language does not appear in the proposed IBHS regulations at **§ 5240.93** (the **Evidence Based Treatment requirements** section), it should be placed there to emphasize that model interventions, such as the one that I have developed and tested over the past 20 years, should have a place among the resources that can be brought into the life of a child with Autism or another disability. The exclusion of anything except "evidence based" treatment is a mistake. At one time, penicillin was not "evidence based" either, but fortunately, people continued to use it because it helped. It doesn't make sense to rule out treatment that *works*, just because it hasn't yet received the recognition it truly deserves from authorities who surely *ought to* recognize it, based on repeated research findings.

9. I have been assured by top DHS officials that the organizations that I created (the Network for Behavior Change and the Children's Behavioral Health Center) would both be eligible for licensure under the proposed IBHS regulations. While this was tremendously reassuring news to hear, I would like to see language added to the IBHS regulations that would explicitly permit licensed psychologists to be providers of IBHS, and not just "agencies" or "facilities." I haven't needed an "agency" to deliver BHRS at an extremely successful level for over 20 years. Misbehaving psychologists have been removed from the Medicaid system when necessary in the past, so the proposed IBHS regulations create a need where none has existed before, and I think that a simple "grandfather" clause would be appropriate. I'm already delivering the services that would constitute IBHS at a high level of skill and success, and have been doing so for 20 years (hence the assurance by top DHS officials of my eligibility to enroll either entity as an "IBHS agency"), but the lack of language within the proposed IBHS regulations to confirm the eligibility of my organizations is troubling.

   Why not just allow licensed psychologists to remain enrolled in Medicaid, as they have been for the past 40 years or more, -- especially those with decades of successful BHRS experience -- and simply expect them to meet the standards set in the proposed IBHS regulations? There is no greater advocate for the needs of a client in treatment than the licensed professional who is rendering that treatment. If they are functioning within the ethical standards of their profession, they have an absolute duty to defend their client's need for treatment, and the funding necessary for it. Not all psychologists perceive this requirement as clearly and definitively as I do, certainly, but the number of "agencies" that defend the needs of their clients is so small as to be nonexistent. The Office of Hearings and Appeals has told my staff many times over the years: *"Why are you the only BHRS provider in the State that ever files Fair Hearing requests?"* That question speaks volumes, doesn't it.

10. It should not be permissible for the Department of Human Services to limit the capacity of a licensed practitioner of the healing arts (those who are allowed to prescribe BHRS or other EPSDT funded treatment in Pennsylvania) to any particular set of prescription options. If the prescriber is licensed by the Department of State to practice the profession of psychology, it should not be permissible for the Department of Public Welfare to regulate that practice.

    Some reviewers have the impression that the proposed IBHS regulations require that any child with an Autism Spectrum Disorder (ASD) diagnosis must receive "ABA" treatment. I do not perceive that mandate within the proposed IBHS regulations myself, but I am concerned that others do. There is no question that, although "ABA" is an evidence-based practice, the possession of a certification as an "ABA provider" is superfluous; if the treatment complies with ABA principles and practices, then "ABA" is being delivered, and it is very easy to examine a treatment plan and treatment documentation to determine if "ABA" treatment is, in fact, being delivered. Accordingly, setting rigorous explicit <u>standards</u> for the creation of developmentally appropriate treatment plans and outcome data collection, at least, should be the goal of the IBHS regulations. Granting the privilege to work only to those who have obtained a recently minted "credential" (including a new "agency license") never has been, and never will be, a solution to the problem of professional incompetence. Only professional peer review can address that.

    It is my strong recommendation that the practice of psychology should not be regulated by the Department of Human Services and that psychologist's prescribing practices should be based on modern research, national standards of care, clinical experience, and the needs of the individual child coming before him/her for evaluation. To say that only "Evidence Based" practices, or only "ABA" treatment, or any other sort of treatment (whether it is enjoying fad status or has a sound empirical basis for its use) is <u>mandatory</u> for any identified class of treatment recipients seems to be a violation

of the anti-discrimination statutes within the Medicaid Act and elsewhere[1] and/or violation of the law governing the practice of psychology, especially when it is targeting the exploding population of children with ASD – for whom very few certain answers exist. The age-old saying *"If you've met one child with Autism, you've met one child with Autism"* should remind us that no matter who you are or what your skills/experience as a clinician, the child coming before you is a unique individual who deserves all of the expertise you can bring to his/her treatment, and that "off label" prescriptions **do** work wonders at times.

11. It would be considerate to grant holders of Provider Type 19 organization status, or holders of Provider Type 11 organization status, a period of time within which they can acquire the necessary credentials in order to apply successfully for IBHS agency licensure. At present, there is no allowance within the proposed IBHS regulations for an orderly transition from "BHRS provider" to "IBHS provider" for psychologists (Type 19 providers), or for other providers that are not "agencies" or "facilities" already. It would be appropriate to grant the same time frame leeway that is granted to existing BHRS "agencies" and "facilities" so that children could continue to receive effective, successful treatment without interruption by the BHRS to IBHS transition.

I sincerely appreciate the opportunity to make these observations and recommendations regarding the proposed IBHS regulations and will continue to review the comments of others throughout the comment period that may prompt additional input. I believe that the IBHS regulations are a step forward, with the exceptions I have noted above, and that the lives of children enrolled in Medicaid could benefit from their implementation if amended.

Respectfully submitted,

Steven Kossor
Digitally signed by Steven Kossor
Date: 2018.08.22 22:51:40 -04'00'

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[1]According to section 504 of the Rehabilitation Act, discrimination is prohibited on the basis of disability. Section 1557 of the Affordable Care Act prohibits health programs and activities receiving federal financial assistance from discriminating and incorporates section 504 of the Rehabilitation Act. Discrimination includes giving members of one group preferential consideration in determining the "medical necessity" of their prescribed treatments and funding those treatments at a higher amount, wider scope or longer duration than members of other groups (with comparable disability symptoms). An example of this would be giving longer-term or higher hours of treatment authorization for children with ASD diagnoses than children with ADHD diagnoses when they display comparable symptoms in frequency and severity. BHRS practices have been rife with this sort of discrimination since the passage of Act 62 in Pennsylvania which ushered in an era where children with ASD diagnoses began receiving preferential deference by insurance companies and others and children with comparable (or worse) symptoms but who did not have ASD diagnoses were subjected to the imposition of arbitrary limits on the amount, duration and scope of treatment authorized. The phrase *"these were supposed to be time-limited services"* is never uttered in the case of children with ASD diagnoses, but it is frequently used to deny authorizations for the treatment of the same (or worse) symptoms in children with ADHD or other non-ASD diagnoses. The proposed IBHS regulations should address that problem; it should be fixed in any case.

Additional Responses to IRRC Number 3209 regarding proposed IBHS Regulations

Steven Kossor 8/22/2018

The following are selected sections from the 142 page .pdf document submitted for IRRC review #3209. I am providing these selections to make it easier for others to understand key components of the proposed IBHS regulations. The actual proposed IBHS regulations appear as **Annex A** starting on page 74 of the document. Quoted text from these pages is indented in Times New Roman font. Pages 1-73 are commentary by DHS authorities in support of the proposed IBHS regulations and appear in this font. Unanswered questions suggested by the wording of the proposed IBHS regulations are labelled "Commentary" and presented in **bold blue font** below the text referenced.

Page 52 of the 142 page .pdf document (marked *Page 25* of the document quoted)

> ***Accomplishments and Benefits***
>
> The proposed rulemaking benefits children, youth and young adults under 21 years of age with mental, emotional and behavioral health needs by promoting quality services by establishing a minimum standard for licensure of IBHS agencies, minimum requirements for IBHS agencies to enroll in the MA Program and conditions for the MA Program to pay for IBHS. Additionally, the supervision and training requirements included in the proposed rulemaking will contribute to the development of a qualified IBHS workforce to deliver treatment services, which will also help to improve clinical outcomes for children, youth and young adults receiving IBHS.
>
> The proposed rulemaking will also improve the accessibility of behavioral health care for children, youth and young adults under 21 year of age by eliminating requirements that have been identified as barriers to accessing services by workgroup members such as convening an ISPT meeting prior to the delivery of services and completing a comprehensive evaluation prior to a referral for services. In addition, the proposed ...

Page 53 (page 26 of the document quoted)

> ... rulemaking promotes the use of additional evidence-based practices and ABA services which may reduce the need for higher levels of care or out-of-home placements for children, youth and young adults.

Commentary: If a licensed practitioner of the healing arts (a physician or a psychologist in PA) doesn't do an evaluation (including a face-to-face examination of the child) and render a prescription for a covered service (like BHRS or IBHS), the entire basis for billing EPSDT for treatment funding doesn't exist. You can't expect a child to get treatment that isn't going to be funded, right? Since IBHS is intended to replace BHRS, the failure to recognize the need for a prescription from a licensed practitioner who is enrolled in Medicaid to justify EPSDT funding for the treatment is inexplicable.

Is it possible that licensed psychologists are expected to "rubber-stamp" prescriptions written by others who don't possess the necessary credentials (with or without a face-to-face examination of the child)? It's a mistake to think that some sort of cursory "assessment" by someone without the necessary license as a practitioner of the healing arts is enough to justify Medicaid EPSDT funding. It isn't, under current Medicaid regulations and it is doubtful that this could be permitted even through the State Plan Amendment process.

INDIVIDUAL SERVICES (not including ABA services)

Page 37 (page 10 of the document quoted)

> ***Individual Services (§§ 5240. 71, 5240. 73, 5240. 75).***
>
> Individual services are intensive one-to-one therapeutic interventions and supports that are used to reduce and manage identified therapeutic needs, increase coping strategies and support skill development to promote positive behaviors with the goal of stabilizing and maintaining a child, youth or young adult in the home, school or community setting. Individual services are provided by behavior specialists, mobile therapists and behavioral health technicians (BHTs).

Page 38 (page 11 of the document quoted)

> **Behavior Specialists (BS)**
>
> ... individuals with graduate degrees in psychology, applied behavioral analysis, social work, education, counseling or related field that includes a clinical or mental health direct service practicum and a minimum of one year of full-time experience in providing mental health direct services to children, youth or young adults can be behavior specialists.
>
> In addition, licensed behavior specialists are qualified to be behavior specialists.
>
> If the behavior specialist provides individual services to a child diagnosed with autism spectrum disorder (ASD) **for the treatment of ASD**, the behavior specialist must have the same qualifications as a behavior specialist analyst that provides ABA services.

Commentary: Emphasis was added in bold in the preceding paragraph. This same text appears periodically in the proposed regulations to specify that services "for the treatment of ASD" are different from services for the treatment of other symptoms. This means that "individual" IBHS could be delivered to a child not diagnosed with an Autism spectrum disorder (ASD), or to a child *with* an ASD diagnosis <u>for the treatment of the child's ADHD or other symptoms</u> by a Behavior Specialist without a license or other IBHS credential. It would be only when Behavior Specialist services would be delivered *"for the treatment of ASD"* that a license would be required of the Behavior Specialist, regardless of the child's diagnosis, which is a different standard than the one in place now.

Page 105 (page 47 of the document quoted)

> **§ 5240.71. Staff qualifications.**
>
> (a) Except as set forth in subsection (b) **[regarding Behavior Specialists who provide individual services to children diagnosed with ASD for the treatment of ASD]**, a behavior specialist who provides individual services shall meet one of the following:
>
> (1) Be licensed in Pennsylvania as a behavior specialist.
>
> (2) Have a current certification as a BCBA from the Behavior Analyst Certification Board or other graduate level certification in behavior analysis that is accredited by

the National Commission for Certifying Agencies or the American National Standards Institute.

(3) Have a graduate degree in psychology, applied behavioral analysis, social work, education, counseling or related field that includes a clinical or mental health direct service practicum from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation and a minimum of one year of full-time experience in providing mental health direct services to children, youth or young adults.

Commentary: All current BSCs without licenses could not deliver or bill for services *to treat ASD symptoms* (currently only the billing for such services is prohibited via Act 62). However, if the services delivered are to treat ADHD symptoms (not "ASD symptoms") then no license is required of the BSC, nor are Behavior Specialist Analyst credentials required to render treatment for a child with an Autism Spectrum Disorder diagnosis – so long as the services were not "to treat ASD symptoms."

Page 38 (page 11 of the document quoted)

Behavioral Health Technician (BHT) *formerly TSS provider*

An individual can be a BHT if the individual has or obtains ... a behavior analysis certification from a nationally recognized certification board or the Pennsylvania Certification Board.

Page 103 (page 49 of the document quoted)

If the BHT does not have the required certification, the BHT can provide individual services for 18 months *after* being hired by an IBHS agency as a BHT or for two years after the effective date of these regulations, whichever is later, if the BHT meets one of the following:

(1) Have a bachelor's degree in psychology, social work, counseling, sociology, education or related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation.

(2) Have an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.

(3) Have an associate's degree or at least 60 credits towards a bachelor's degree and a minimum of one year of full-time experience in providing mental health direct services to children, youth or young adults.

4) Have a Pennsylvania license as a registered nurse and a minimum of one year of full-time experience in providing mental health direct services to children, youth or young adults.

Commentary: A current TSS provider would have up to 18 months from the date of hire or 2 years from the date of the implementation of the IBHS regulations, whichever occurs later, in which to obtain the required certification as a Behavioral Health Technician in order to continue delivery of any IBHS.

Page 41 (page 14 of the document quoted)

> **Clinical Director**
>
> All clinical directors of IBHS agencies must be licensed or certified.

Commentary: Licensure as a psychologist is sufficient to be a Clinical Director of an IBHS agency. However, if the agency were to deliver "ABA" services, the credentials of the Clinical Director would have to be higher. If "ABA" services were to be delivered by a *different* agency, the Clinical Director of *that* agency would have to have the BCBA certification and other necessary credentials.

APPLIED BEHAVIOR ANALYSIS (ABA)

Page 41 - 42 (pages 14 -15 of the document quoted)

> ***ABA (§§ 5240.81-5240.83, 5240.87).***
>
> The proposed rulemaking **separately** identifies ABA as an intensive behavioral health service that can be provided by qualified staff to children, youth or young adults with autism and other behavioral health disorders. ABA is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function. ABA can be used for skill development and to target behaviors that impact the ability of the child, youth or young adult to function in the home, school or community setting.
>
> **Clinical Director – ABA**
>
> All clinical directors of IBHS agencies must be licensed or certified, but the clinical director of an IBHS agency that provides ABA must either have a current certification as a board certified behavior analyst (BCBA) from the Behavior Analyst Certification Board or other graduate level certification in behavior analysis from a nationally recognized certification board, or a graduate degree in ABA and a minimum of one year of full-time experience in the provision of ABA and obtain BCBA certification or other graduate level certification in behavior analysis from a nationally recognized certification board within three years from starting work as the clinical director for any IBHS agency.
>
> ABA can be provided by a behavior specialist analyst, assistant behavior specialist analyst (ASSA) and a BHT-ABA.

Commentary: If a BHT or BSC is not providing "ABA" treatment, they do not require "ABA" credentials. The delivery of "ABA" services is not restricted to children with ASD diagnoses, so children with ASD diagnoses do not necessarily need to receive "ABA" services to the exclusion of all other services. If a BHT or BSC is not delivering services *for the treatment of ASD* then they can deliver such services to a child, and bill for them, as "individual" services, whether or not the child has an ASD diagnosis; they cannot deliver services *for the treatment of ASD* without the credentials needed to deliver "ABA"

services, but general behavioral interventions such as, contingency contracting, positive behavioral reinforcement, modeling, shaping by successive approximations, etc. can be delivered by a BSC or BHT to a child *with* (or without) an ASD diagnosis to treat ADHD or other symptoms, so long as the services delivered to the child are *not for the treatment of ASD.*

> **Behavior Specialist Analyst (BSA)**
>
> Behavior specialist analysts must be licensed as a psychologist, professional counselor, marriage and family therapist, clinical social worker, social worker or behavior specialist and have ...

Page 43 (page 16 of the document quoted)

> ... or a minimum of one year of full-time experience in the provision of ABA under the supervision of an individual with a graduate level certification in behavior analysis.

Commentary: Anyone with an approved Service Description as a Behavior Specialist Consultant (including a licensed psychologist, licensed Behavior Specialist, or a psychologist's supervisee who has functioned in the role of a Behavior Specialist Consultant), who has worked under the supervision of an individual with a graduate level certification in behavior analysis for at least one full year at some point in their post-graduate career can work as a Behavior Specialist Analyst from that point onward, without requiring any additional supervision from the person with a graduate level certification in behavior analysis.

Page 114-115 (pages 59 and 60 of the document quoted)

> A behavior specialist analyst who provides ABA services shall have a Pennsylvania license as a psychologist, professional counselor, marriage and family therapist, clinical social worker, social worker or behavior specialist and have one of the following:
>
> (1) A current certification as a BCBA from the Behavior Analyst Certification Board or other graduate level certification in behavior analysis that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute.
>
> (2) A current certification as a BCaBA from the Behavior Analyst Certification Board or other undergraduate level certification in behavior analysis that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute.
>
> (3) A current certification as a behavior specialist analyst with a competency in ABA from the Pennsylvania Certification Board.
>
> (4) A minimum of 12 credits in ABA from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation and one year of full-time experience in the provision of ABA.
>
> (5) A minimum of one year of full-time experience in the provision of ABA under the supervision of a professional with a certification as a BCBA from the Behavior

Analyst Certification Board or other graduate level certification in behavior analysis that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute.

Commentary: A BSC *who is not treating the symptoms of Autism* can deliver ABA services or other services as a Behavior Specialist Analyst to any child (with or without an Autism diagnosis) without needing a license or other credential if he/she has acquired *a minimum of one year of full-time experience in the provision of ABA under the supervision of a professional with a certification as a BCBA from the Behavior Analyst Certification Board prior to the delivery of the Behavior Specialist Analyst services.*

Page 43 (page 16 of the document quoted)

Behavioral Health Technician (BHT-ABA)

A BHT-ABA (formerly a TSS worker **[providing ABA services, or TSS-ABA]**) must have ... a behavior analysis certification from a nationally recognized certification board or the Pennsylvania Certification Board. ... The Department will be engaging the Pennsylvania Certification Board to develop a state specific certification in ABA for BHTs based upon the recommendations of stakeholders.

If an individual does not have the required certification, the individual can be a BHT-ABA for 18 months after being hired by an IBHS agency as a BHT-ABA or for two years after the effective date of the regulations, whichever is later, if the individual has a bachelor's degree in psychology, social work, nursing, counseling, education or related field

Page 45 (page 18 of the document quoted)

... a BHT-ABA who does not have an undergraduate certification in behavior analysis must complete the initial training requirements for a BHT that provides individual services and the training requirements a BHT must complete during the BHT's first six months of employment.

In addition, a BHT-ABA who does not have an undergraduate certification in behavior analysis must complete at least 20 hours of training related to ABA that is approved by the Behavior Analyst Certification Board or the Department before independently providing ABA services to a child, youth or young adult and at least 20 hours of training annually that is approved by the Behavior Analyst Certification Board or the Department that is related to the BHT-ABA's specific job functions.

Commentary: A BHT can deliver ABA or other services to a child with an Autism spectrum disorder (ASD) if the services are rendered to treat ADHD or other symptoms (not for the treatment of ASD). The treatment plan needs to specify the purposes of the service delivery and if they are not delivered *for the treatment of ASD,* then they can be delivered by BHT or other providers, regardless of the diagnosis of the child being treated.

Page 43 - 44 (pages 16 - 17 of the document quoted)

Assistant Behavior Specialist Analyst (ABSA)

The proposed rulemaking also includes a staff position that allows a professional who meets all of the requirements for licensure as a behavior specialist under 49 Pa. Code § 18.524 (relating to criteria for licensure as a behavior specialist) with the exception of the experience requirement to be employed as an ABSA.

An individual who has a bachelor's degree in psychology, social work, counseling, education or related field and an undergraduate level certification in behavior analysis **or at least 12 credits in ABA** and six months of experience in providing ABA can also be employed as an ABSA.

Pages 115-116 (pages 60 and 61 of the document quoted)

An ABSA who provides ABA services shall meet one of the following:

(1) Have all of the qualifications for licensure as a behavior specialist under 49 Pa. Code § 18.524 (relating to criteria for licensure as a behavior specialist) except the experience required under subsection (c).

(2) Have a bachelor's degree in psychology, social work, counseling, education or related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation and a current certification as a BCaBA from the Behavior Analyst Certification Board or other undergraduate level certification in behavior analysis that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute.

(3) Have an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services and a current certification as a BCaBA from the Behavior Analyst Certification Board or other undergraduate level certification in behavior analysis that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.

(4) Have a bachelor's degree in psychology, social work, counseling, education or related field from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation and at least 12 credits in ABA from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation and six months of experience in providing ABA.

(5) Have an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services and at least 12 credits in

ASA from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services and six months of experience in providing ABA. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.

Commentary: A person who qualifies as an ABSA can deliver treatment of any sort to any child for the treatment of ADHD or other behavioral challenges regardless of the child's diagnosis, and can deliver ABA treatment to a child with an ASD diagnosis for the treatment of ASD symptoms in that child as well.

Page 45 (page 18 of the document quoted)

Evidence-Based Therapy (EBT) (§ 5240.93).

EBT is behavioral health therapy that uses scientifically established behavioral health interventions. The proposed rulemaking requires that an IBHS agency be licensed or certified from the entity that developed or owns the EBT that is being provided if required [by the entity that developed or owns the EBT] to provide the EBT.

An IBHS agency can also use a model intervention that it has developed and that has been designated by the Department as a model intervention. This will provide IBHS agencies with the opportunity to expand the service array to meet the therapeutic needs of children, youth and young adults.

Commentary: The preceding paragraph about Model Interventions does not appear in the Proposed IBHS Regulations in the location cited (see below). It should be added there.

Pages 130-131 (pages 74-75 of the document quoted)

§ 5240.93. EBT requirements.

(a) An IBHS agency shall have a certification or license from the national certification organization or entity that developed or owns the EBT if required to provide the EBT.

(b) An IBHS agency shall ensure that EST is provided by staff that meet the qualifications and receive supervision as set forth in the EBT.

(c) An IBHS agency that is using an EBT shall have written policies and procedures to measure:

(1) The adherence to the implementation of the specific EBT.

(2) The outcomes of the EBT that incorporate review standards associated with the EBT.

(d) An IBHS agency using an EBT shall continuously monitor the fidelity to the EBT.

(e) An IBHS agency shall ensure that procedures related to and decisions about continuing services and discharge are made in accordance with the specific EBT.

(f) An IBHS agency that does not meet the standards of the EBT that is provided shall:

(1) Have a corrective action plan that is approved by the national certification organization or the Department.

(2) Track the corrective action plan to ensure that the plan has been implemented.

(3) Complete the corrective action plan to meet the standards of the EBT within the time frame identified in the corrective action plan.

Pages 104-105 (pages 49 and 50 of the document quoted)

§ 5240.72. Supervision.

(a) Supervision shall be provided by an IBHS supervisor to all staff that provide individual services. Supervision shall include at least the following:

(1) One hour of supervision of behavior specialists and mobile therapists two times a month.

(2) One individual face-to-face session a month for each IBHS staff person.

(3) Thirty minutes of direct observation of services being provided by each IBHS staff person every three months.

(4) Case reviews for each IBHS staff person each month that includes:
(i) The interventions being implemented.
(ii) ITP implementation status.
(iii) Adjustments needed to the ITP goals.
(iv) Staff person's skill in implementing the ITP interventions.

(b) In addition to the requirements in subsections (a) (2)-(4), an IBHS supervisor shall provide a BHT with the following supervision:

(1) Six hours of on-site supervision during the provision of services to a child, youth or young adult prior to providing services independently.

(2) On-site supervision during the provision of services to a child, youth or young adult at least quarterly for a minimum of 30 minutes.

(3) One hour of supervision each week if the BHT works at least 37.5 hours per week or one hour of supervision two times a month if the BHT works less than 37.5 hours a week.

(c) An IBHS supervisor shall meet one of the following:

(1) Be licensed in Pennsylvania as a psychologist, professional counselor, marriage and family therapist or clinical social worker.

(2) Be licensed in Pennsylvania as a certified registered nurse practitioner and have a mental health certification.

(3) Be licensed in Pennsylvania as a social worker with a graduate degree that required a clinical or mental health direct service practicum.

(4) Have a graduate degree in psychology, applied behavioral analysis, social work, education or a related field that includes a clinical or mental health direct service practicum from a college or university accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation and a minimum of one year of full-time experience in providing mental health direct services to children, youth or young adults.

(5) Have an equivalent degree from a foreign college or university that has been evaluated by the Association of International Credential Evaluators, Inc. or the National Association of Credential Evaluation Services and a minimum of one year of full-time experience providing mental health direct services to children, youth or young adults. The Department will accept a general equivalency report from the listed evaluator agencies to verify a foreign degree or its equivalency.

(d) An IBHS supervisor may supervise a maximum of nine full-time equivalent BHT staff.

(e) Group supervision may be provided to no more than nine mobile therapists, behavior specialists and BHTs in each session.

(f) Face-to-face supervision may be delivered through secure, real-time, two-way audio and video transmission that meets technology and privacy standards required by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936). ...

(i) The clinical director may provide supervision if the IBHS agency employs nine or less full-time equivalent staff that provide individual services and have no staff that meet the qualifications of an IBHS supervisor.

Commentary: Current TSS supervisors can continue to supervise BHT providers of individual services as well as providers of BHT-ABA services. There are no special requirements or qualifications for the providers of supervision to BHT-ABA providers, although the *amount* of supervision and the *processes* involved in its delivery are different.

Page 49 (page 22 of the document quoted)

Waivers (§ 5240.111).

The proposed rulemaking allows an IBHS agency to submit a written request to the Department for a waiver of a specific requirement of Chapter 5240. The Department may grant a waiver unconditionally or subject to conditions that must be met and may revoke a waiver if conditions required by the waiver are not met.

The Department will grant a waiver only in exceptional circumstances and if

- the waiver does not jeopardize the health and safety of the children, youths or young adults served by the IBHS agency;
- the waiver will not adversely affect the quality of services provided by the IBHS agency;
- the intent of the requirement to be waived will still be met;
- children, youth or young adults will benefit from the waiver of the requirement and
- the waiver does not violate any Federal or State statute or other regulation.

Commentary: Waivers do not appear to be a viable means of resolving any of the questions in this paper, so their resolution should be addressed directly in the proposed IBHS regulations.

Respectfully submitted,

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