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From: Suhring, Scott <ssuhring@cabhc.org>
Sent: Tuesday, September 04, 2018 9:44 AM
To: PW, IBHS
Cc: Board; Powanda, Michael
Subject: CABHC Comments to draft IBHS regulations
Attachments: CABHC Comments to Draft IBHS regulations 09 04 18.pdf

Please find attached our comments to the draft IBHS regulations. If you have any questions, please feel free to contact me.

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September 4, 2018

To: Independent Regulatory Review Commission

From: Scott Suhring

Re: *Proposed Rulemaking; Department of Human Services; [55 PA. CODE 1115 and 5240]; Intensive Behavioral Health Services*

The following comments on the Proposed Rulemaking; Department of Human Services; [55 PA. CODE 1115 and 5240]; Intensive Behavioral Health Services are being submitted for your consideration.

1. Throughout both regulations related to staff qualifications, it identifies inclusion of the Pennsylvania Certification Board as meeting the criteria for several positions. It is unclear what this would entail and how these standards would be set. Therefore, it is not possible to offer comment on this staffing requirement and if it would or would not be adequate to meet the qualifications of the referenced position. Also, when would these be developed?
2. **§ 1155.2. and § 5240.2 Definitions *EBT* (v).** It is unclear how a model designated by the Department can qualify as an EBT. Items (i) through (iv) all have clear research-based support to their qualification and should accommodate all considerations for EBT. By adding a designation by the Department could undermine the validity of calling a treatment as EBT. It is recommended that this be removed from all EBT definitions.
3. **§ 1155.22 Ongoing responsibilities of providers. (c)** Are these separate licenses and thus review or are satellites listed and reviewed as part of the "home" license? It would be recommended that they each retain their own license and must be reviewed individually.
4. **§ 1155.32 Payment conditions for individual services; § 1155.33 Payment Conditions for ABA; § 1155.34 Payment Conditions for EBT and § 1155.35 Payment Conditions for group services (1) (ii)** This provides for the prescribing professional to have the ability to write a prescription for a child, youth or young adult with minimal assessment or the completion of a comprehensive evaluation to determine the most appropriate treatment that meets the treatment needs of the child. One of the most critical aspects for the initiation of any treatment is to provide a comprehensive evaluation to make sure that the child who needs treatment is properly diagnosed and all considerations are reviewed before prescribing a treatment approach. This is much more critical for

children, youth or young adults who do not have an Autism diagnosis since Serious Emotional Disorders can be attributed to many factors and the course of treatment, if not properly diagnosed, could be harmful to the child and family. By downplaying the importance of this first engagement with the professional evaluator and shifting the comprehensive evaluation over to the provider could result in providers assuring that the prescription is upheld and deterring a provider from having an assessment result in the identification of another course of treatment that would be best for the child and family. It was noted during the IBHS regulation committee meetings that this approach is similar to when a physician diagnoses a sprained ankle and makes a prescription to a physical therapist who then does a more comprehensive assessment and develops the course of treatment. This would make sense except for the fact that diagnosing a sprained ankle is not the same as a SED. This change in the current diagnosing, assessment and prescribing should be revised and there should be more emphasis placed on the completion of a comprehensive evaluation that would then lead to a more informed and supported diagnosis and prescription. The assessment and ITP development by the provider is still needed and should be retained.

The other issue regarding this change is that there would be very little information for Medical Necessity determination to be made by either FFS or the Managed Care Organization under HealthChoices. Once the prescription is made, MN determination would have to be made before the provider could begin the assessment, ITP development and treatment being started. By providing a comprehensive evaluation by the prescribing professional, MND could be made.

5. **§ 1155.32 Payment conditions for individual services; § 1155.33 Payment Conditions for ABA; § 1155.34 Payment Conditions for EBT and § 1155.35 Payment Conditions for group services (ii)** This section allows other licensed professionals whose scope of practice includes diagnosis and treatment of BH disorders. It is unclear how this is determined. Is it based on MH OP regulations as to who can diagnosis? Is it determined by the licensing board? Please clarify this inclusion in who can prescribe IBHS.

6. **§ 1155.32 Payment conditions for individual services; § 1155.33 Payment Conditions for ABA; § 1155.34 Payment Conditions for EBT and § 1155.35 Payment Conditions for group services (iv)** It should be clearly noted in the definitions that the Order of one or more IBHS must be a service that has an approved service description (this is not cited in the definitions). It is not uncommon for a prescriber to issue a prescription for a service they feel is needed that does not exist or uses language that does not match up with an approved service description. It will be critical that prescribes have a comprehensive understanding of all services and their descriptions if they are to appropriately prescribe services, both for IBHS or for other services funded by Medicaid and HealthChoices.

7. **§ 1155.32 Payment conditions for individual services; § 1155.33 Payment Conditions for ABA; § 1155.34 Payment Conditions for EBT and § 1155.35 Payment Conditions for group services (1)** It appears that duration of treatment is no longer required to be part of the prescription and that it defaults to 6 months or 12 months. Is this correct and if so, how are time limited services that would typically fall

under Group Services be managed by the MCO? It is recommended that duration be required in the order and be tied to (1)(iv)(D).

8. **§ 1155.32 Payment conditions for individual services; § 1155.33 Payment Conditions for ABA; § 1155.34 Payment Conditions for EBT and § 1155.35 Payment Conditions for group services (7)** Does the written order that allows for reinitation of services up to 60 days after discharge require a face to face assessment in order to generate the renewed prescription for treatment to continue? The requirement for a written order seems to contradict what is stated in the 5240 regulations which only requires the request from the parent or guardian. What if the discharge occurred at the end of the current prescription and there is no valid prescription to restart services? What is the expectation of the IBHS provider to retain staff who was working with the child so that continuity of care could be realized if services need to restart? This would not be practical for the IBHS provider to manage. All of these questions would require further clarification of this expectation for both the IBHS provider and the MCO to comply with this regulation.
9. **§ 1155.33 Payment Conditions for ABA (4)** Based on the required time lines for the ITP and the need to complete a Functional Behavioral Assessment (unless FBAs are no longer required for ABA services), this section would seem to imply that the assessment must be completed in less than 30 days to account for the inclusion in writing the ITP. This period of time may not be adequate to complete a comprehensive FBA.
10. **§ 1155.34 Payment Conditions for EBT** The entire inclusion of EBT as a separate service is very confusing and it is unclear how this would be included in the IBHS. An example for this confusion is Parent Child Interaction Therapy or Trauma Focused Cognitive Behavioral Therapy. PCIT is an EBT and if ordered, it would be delivered in a licensed Mental Health Outpatient clinic. If a prescription is for PCIT, could this be delivered in either the clinic or as an individual IBHS treatment if there is a service description to deliver this in the clinic? For TF-CBT, a prescription could be for TF-CBT and it could be delivered by a Mobile Therapist or by a therapist in a licensed MH OP Clinic. The prescription under IBHS would be for MT and it is up to the therapist to determine what is the best treatment approach to take. This is the same for a MH OP Clinic. By listing EBT as a separate service, it implies that EBT cannot be provided under individual, group or ABA services, since they are each listed separately. It is recommended that the reference to EBT should be included in individual, group and ABA as a preferred treatment approach to be used in all three and not be a stand-alone service.
11. **§ 1155.35 Payment Conditions for group services.** Can group services be delivered as a center or facility based service? If so, what regulations will be used to assure that the facility of the center based treatment meets the safety and physical needs of the children, youth and young adults?
12. **§ 1155.41 Scope of claims review.** This section does not accommodate the required utilization review process as contractually mandated under the HealthChoices Behavioral Health Program Standards and Requirements. Previous comments to the MND shortcomings with the prescription process would be near impossible to conduct and comply with the contractual terms. Since HC BH will pay over 90% of all IBHS, this needs to be addressed in this section and others of the regulations.

13. **§ 5240.5 Service description.** What role does the County MH/ID and/or the BH MCO, as the Health Choices Behavioral Health Program Primary Contractor, have in the review of the service description? Since there would always be a financial impact on the approval of any service description as well as the clinical direction that the County/BH MCO is supporting for its members, exclusion of this review could place the program at financial risk and may contradict clinical efforts to improve the care of its members. Inclusion of the review and approval of a IBHS provider's service description must include the County and BH MCO in the process and should be included in the regulations.

14. **§ 5240.7 Coordination of services. (f)** It is unclear why an IBHS agency that provides group services would not be required to comply with subsections (a) and (b). No mater how an IBHS agency is delivering services (individual, group or ABA), coordination with other child serving treatment agencies would be critical. A child could be in a group service and still be receiving MH OP services, most notably medication management. This would also be true for a child who would need crisis intervention services while receiving treatment in a group service. This section should be removed.

15. **§ 5240.11 Staff requirements. (e)** Is the reference to the administrative director dedicating 7.5 hours each week for each IBHS "agency" that he directs the same as licensed program and services or is the reference to agency literally multiple agencies? If it is licensed programs, there should be a limit to the number of licensed programs that a single administrator can oversee since there would not be enough hours in a week if more then 5.

16. **§ 5240.21 Assessment.** As noted earlier, much of the identified aspects of this assessment should be done by the prescribing professional since this is necessary to complete a comprehensive evaluation to make an appropriate diagnosis and to determine the best treatment to meet the child's needs. Requiring this after the prescription fails to allow for proper MND to be reviewed and the provider has no incentive to assure that the service is appropriate for the child since they must follow the prescription.

17. **§ 5240.21 Assessment. (a).** What happens if due to scheduling issues or provider capacity the assessment cannot be done within 15 days? Does this become a citation issue with licensing or does this disqualify the provider being able to bill for services?

18. **§ 5240.21 Assessment. (b).** This should include "young adult" to be consistent with other such references.

19. **§ 5240.21 Assessment. (e).** Is there no requirement for a new evaluation to be completed to issue another prescription or order for the services? This would seem to imply the provider completes a new assessment and services continue based on the outcome of the assessment. This would contradict all mandated utilization review and medical necessity determination under the HealthChoices Behavioral Health program standards and requirements. A new evaluation and if appropriate, prescription must be required to continue treatment.

20. **§ 5240.21 Assessment. (h)** This section indicates that Subsection (a) does not apply to EBT or group services. Any implementation of services by a provider should include an assessment to guide them and the member in the course of treatment and the development

of the ITP. Also, if you do not require (a), then requiring (b) through (e) would not apply.

21. **§ 5240.22 Individual treatment plan. (d)(1)** If it is not until the ITP that the number of hours for each service is determined, how can this be associated with the prescription and how can medical necessity be determined? This would allow the provider to deliver as many hours as they determine, which could be influenced by financial gains, available staffing and other factors that have no relationship to the actual needs of the child.
22. **§ 5240.22 Individual treatment plan. (2)** By using the term "Whether" in determining if the parent or care giver participation is required would contradict all best practice in the treatment of children. This should be changed to how the parent or caregiver will participate in treatment.
23. **§ 5240.31 Discharge. (c).** This was commented on earlier. What if the period of time of the continuation exceeds the time period of the initial prescription, order? What if provider cannot staff with same staff assuring continuity of services? What if provider does not agree to the request?
24. **§ 5240.32 Discharge summary.** Who is qualified to write the discharge summary?
25. **§ 5240.41 Individual Services, Staff qualifications. (d)** Can a Registered Behavioral Technician be eligible to be a Behavioral Health Technician with only a high school diploma? This would be supported but it is not clearly identified since other certifications may be permitted (PCB) which may or may not allow a high school diploma. Also, (d) (1) requires a bachelors degree.
26. **§ 5240.72 Supervision** Please clarify if this is intended to be clinical supervision or administrative supervision. This question applies to all Supervision sections.
27. **§ 5240.72 Supervision (a) (2)** and **(3)** Does this include Behavioral Specialists and BCBAs? If so, you could have a supervisor that is less qualified clinically than who they are supervising. This would not be appropriate.
28. **§ 5240.72 Supervision (e)** Does this mean in total for each staffing qualification or in total (i.e. 9 BS, 9 MTs and 9 BHT or 9 BS, MT, and BHT)?
29. **§ 5240.73 Staff training requirements.** Please clarify what and how Department-approved training will be conducted. Does this mean that each provider will have to get their training approved or will the Department set at a later time what this requirement will be?
30. **§ 5240.75 Individual service provision. (a)** Why isn't the BS allowed to develop the ITP when in the next section the MT is permitted to? This should be added to the duties of the BS.
31. **§ 5240.83 Staff training. (b)** Please include in the definition section (§ 5240.2) the definition of a behavioral specialist analysist.
32. **§ 5240.85 Assessment (a)** Is there any time limit to how long the assessment takes? Also, if this must be done prior to developing the ITP, is it assumed this is also prior to delivering any billable services?

33. **§ 5240.72 Assessment (e) (4)** This would require an updated assessment be completed every time a goal is achieved. This would seem to be excessive depending on how a goal is defined and measured.
34. **§ 5240.86 Individual treatment plan. (a)** How can ABA services begin if there is no ITP? Since the requirements of the record keeping clearly indicates all notes must be tied to the ITP goals (§ 5240.41 (a) (7)(ii)), this would be a violation of record keeping and billable activities.
35. **Evidence-Based Therapy** Concern was previously shared regarding the separation of EBT as a service when it should be included in all delivery of services (individual, group and ABA). This should be removed.
36. **§ 5240.101 Group Services Staff requirements and qualifications. (c)** Please provide a definition of a "mental health professional" in the definitions section of the regulations (§ 5240.2). OMHSAS currently has multiple definitions and qualifications of a MHP in various regulations.
37. **§ 5240.101 Staff requirements and qualifications. (c)** Please define mental health worker in section § 5240.2.
38. **§ 5240.101 Staff requirements and qualifications.** I believe that (c) (2) should come before (c) (1)?
39. **§ 5240.105 Assessment (a)** This requirement would almost assure that STAP services could not be in compliance with this time frame.
40. **§ 5240.105 Assessment (b)** The noted referenced section does not appear to be correct.
41. **§ 5240.106 Individual treatment plan.** (f) (2) Why is this only required for 45 days when all other services require 90 days? This is not consistent.
42. **§ 5240.108 Requirements for group services in school settings.** This section should also apply to individual services and ABA services delivered in a school setting. The lack of educational inclusion in the other sections will create continued role and accountability confusion without such requirements being part of licensing. This must address the provider's relationship with the local educational system.