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Champa, Heidi

From:	Samuel Knapp <sam@papsy.org>
Sent:	Friday, August 31, 2018 9:38 AM
To:	PW, IBHS
Cc:	Rachael Baturin
Subject:	Comments on Proposed IBHS regulations
Attachments:	Comments on IBHS Proposed Regulations from PA Psychological Association.docx

Dear Tara Pride:

On behalf of the Pennsylvania Psychological Association, we are submitting these comments on the proposed IBHS regulations.

Thank you.

Samuel Knapp, Ed.D.
Director of Professional Affairs
PA Psychological Association

August 30, 2018

Ms. Tara Pride
Bureau of Policy, Planning and Program Development
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303 Walnut Street
Harrisburg, PA 17105

RE: Proposed Intensive Behavioral Health Services; Regulation No. 14-546
published August 4, 2018 in the *Pennsylvania Bulletin*

Dear Ms. Pride:

On behalf of the Pennsylvania Psychological Association, we are submitting these comments on the proposed Intensive Behavioral Health Services regulations. We commend the Department of Human Services for their work on these proposed regulations. Although there are many positive provisions in these proposed regulations, we have identified areas where the proposed regulations could be improved or where we had uncertainty as to what the regulation meant or how they would be interpreted or applied.

Our concerns focus on

- The requirement of a second credential for licensed psychologists delivering ABA services;
- The removal of licensed professionals from the initial evaluation (15-day) of the child and lack of involvement of licensed professionals in updates;
- The narrow interpretation of evidence-based services;
- Ambiguities concerning reimbursement;
- Concerns about transitions for independent or small group practices who do not currently hold agency licenses from the Department of Human Services;
- Administrative burdens that do not appear justified by the public interest; and
- Failure to allow for the development of integrated care services.

In addition, we have several other questions about specific provisions of these proposed regulations.

Requirement of a Second Credential for Licensed Psychologists

Section §5240.81 (b) (1) requires licensed professionals who deliver ABA services to have a second license or credential in behavioral analysis.

We oppose the position that licensed psychologists must receive a second credential in applied behavior analysis. The practice of psychology as defined by the Professional Pennsylvania's Psychologists Practice Act includes the application of "established principles of learning. . . and behavior adjustment." Behavioral analysis techniques were developed by psychologists and are taught in psychology programs. The American Psychological Association has a division of behavior analysis (Division 25) and the American Board of Professional Psychology, which awards specialty board status to psychologists, offers a diplomate for psychologists with advanced expertise in behavior analysis. Furthermore, many psychologists working mostly independently or in small business have been providing these services for decades and have gathered good outcome data on their services. It would unfairly restrict access to services to restrict the ability of licensed professionals to continue to deliver these services.

Although ABA is part of the practice of psychology, not all psychologists are proficient in this modality. So, it is appropriate for the department to restrict the use of ABA to psychologists with experience or training and competence in applied behavior analysis, as evidenced by graduate coursework, practicum or internship experiences, a sequence of continuing education programs, or years of service successfully delivering this service.

Furthermore, we believe the Department of Human Services is exceeding its authority in this proposed regulation and attempting to overrule the Pennsylvania General Assembly which has made applied behavior analysis a component of the practice of psychologist.

We recommend that licensed psychologists should not be required to have an additional credential or license to perform ABA.

Role of Licensed Professionals in Assessments

The proposed regulations require behavioral specialists or mobile therapists to conduct assessments within 15 days (see §5240.21).

We oppose this provision because the proposed regulations do not require behavior specialists or mobile therapists to have a professional license (see §5240.71). Unlicensed individuals will be assigned the task of making a 15-day assessment without any specific oversight or review by a licensed professional. Similarly, the proposed regulations would not require the input of a licensed professional for a 6-month review (§5240.21).

These provisions threaten the quality of the assessments. We strongly recommend that the regulations require that the 15-day assessment and 6-month update be done either by a licensed professional or under the supervision of a licensed professional who will review and approve the specific recommendations.

To its credit the Departments requires the ITP update to include "a description of progress or lack of progress toward the goals and objectives" (§5240.22 (g) (1)). However, this description of progress is best made if it includes psychometrically sound data based on a standardized test or standardized method of data collection. This would argue for the involvement of a licensed professional in the initial evaluation and the ITP update. The proposed regulations appear to require that the ITP only needs to be reviewed by the supervisor of the licensed professional who developed the ITP. If this is the case, then we believe this process to be flawed as it should involve the participation of the licensed professional in the update to ensure the option of using psychometrically sound data as a part of the progress evaluation.

In addition, the proposed regulations would adopt a standard for evaluations for children that differs from the standard that the Pennsylvania General Assembly adopted in Act 62 of 2008, which would make coordination of treatment between commercial and medical assistance reimbursed services more complicated. Act 62 has established a mandate for autism services that require a diagnostic evaluation performed by a "licensed physician, licensed physician assistant licensed psychologist or certified registered nurse practitioner." We believe that the Department of Human Welfare should adopt the same standards for evaluation of autism as found within Act 62 to ensure continuity of services. Many children move between medical assistance and commercial insurance coverage for their condition. It creates the possibility of a disruption of services when commercial insurers require a set of assessment conditions not found in the proposed Department of Human Services regulations.

Evidence-Based Treatment

We commend the Department for encouraging the use of evidence-based treatment (see §5240.91), but we question how these proposed regulations were written.

First, it is not clear if evidence-based treatments are to be considered a set of treatments that differ from individual, ABA, or group services or whether they represent a set of standards that should apply across all individual, ABA, or group modalities of services. This should be clarified.

Second, the proposed regulations are written in such a way that the Department could demand the return of moneys any time a professional made a clinically indicated adaptation of the evidence-based treatment based on the individual needs of a child. Section §5240.91 dealing with EBT (evidence-based treatment) initiation requirements states that the agency must measure "the adherence to the implementation of the specific EBT" and "monitor fidelity to the EBT" (§5240.93). The problem is that the requirement to measure fidelity could be interpreted as prohibiting clinically indicated modifications to treatment based on individual patient need.

The problem is that treatments designated as evidence-based go through an experimental process wherein the group means for the treatment group are statistically significantly improved compared to the group means of the no-treatment or placebo treatment groups. Nothing in the literature on evidence-based treatments is meant to suggest that the evidence-based treatment is appropriate for all the individuals with the targeted condition. Indeed, many individuals fail to respond to evidence-based treatments and some will deteriorate.

Some leading authorities on evidence-based practices concur with this position. According to one authority,

> RCTs [randomized controlled designs] tell us relatively little about how individuals might respond to the treatment, especially those differing significantly from RCT samples, such as those with comorbid diagnoses or any number of cultural differences. . . RCTs also do not aid clinicians in selecting or tailoring treatments to best match individual strengths, weaknesses, or preferences. The same standardization procedures that are essential for establishing scientific certainty about a given effect also produce treatment approaches that are not easily adapted to new contexts (Crutchfield & Mackronis, 2016, pp. 194-195).

Similarly, another authority stated that clinicians must "adapt ESTs [evidence-supported therapies] for particular clients with specific disorders" (Castonguay, 2013, p. 53). He also cited research that found that the psychotherapists adherence to the treatment manual was negatively correlated with patient outcomes, most likely because they failed to adapt the treatment to meet patient needs.

Response to treatment varies according to many features including the acceptability of the treatment and the comorbid conditions of the patient. Also, it is inconsistent for the Department of Human Services to insist upon individualized assessments (e.g., §5240.22) yet fail to allow for individualized treatment decisions in actual practice. One of the essential goals of assessment is to identify the most helpful treatments. However, the proposed regulations would prohibit professionals from implementing the most helpful treatments for the child if they withhold payments for EBT services that are delivered with modifications made to accommodate the unique comorbidities, family structure, or culture of the child even when such modifications or supplementary services have a clinical justification and are documented in the treatment record.

One can appreciate the position of the Department of Human Services in that it wants to discourage the use of ill-defined and unresearched treatments. Indeed, the history of health care is filled with fads that lack any reasonable theoretical basis or evidence behind them. However, the current wording of the proposed regulations goes too far in the opposite direction and essentially instruct professionals to provide less than acceptable services to children because they cannot modify treatments when clinically indicated.

We recommend that the regulations to include some provision that allows professionals to modify EBT treatments to account for the needs of individual children.

Furthermore, treatments are designated as evidence-based for individuals of a certain age and condition. However, not all ages or conditions have evidence-based treatments identified for them. It is unreasonable to ask professionals to provide evidence-based treatments when none exists for a child.

Finally, our members have brought to our attention that some managed care companies will restrict the services that the professionals recommend. So, it is possible that a managed care

company may impose restrictions on the type or intensity of services provided that prohibit the professional from adhering to the protocol for an evidence-based treatment. We do not believe that professionals should be penalized when managed care companies prohibit them from delivering evidence-based treatments.

Reimbursement Issues

The proposed regulations raise many questions about reimbursement such as concerns concerning the 15-day evaluation, about the lack of reimbursement for direct consultations with parents or teachers even when the child is the focus of the consultation, confusion over the definition of medical necessity, and lack of reimbursement for supervised services.

Payment Depending on Mandated Individual Evaluations within 15 Days

Section §1155.32 (Payment conditions for individual services) specifies that payment requires a "written order for services based on a face-to-face interaction with a child. . ." written within 6 months prior to the initiation of services and so on. Furthermore, that same section specifies that payment shall only occur if the child also has a "comprehensive face-to-face assessment by a behavior specialist or mobile therapist within 15 days of the initiation of individual services" (§11.55.32 (2)).

However, the proposed regulations preclude the option of having the child go directly to a comprehensive evaluation for the ITP which must include a licensed professional. We believe the regulations should allow the option of having the 15-day evaluation, but also permit the child to go directly to the 30-day ITP/licensed professional evaluation.

Limitations on Services

Behavior specialists and other treatment providers should be paid when they consult to parents and teachers. The current regulations do not allow for this option and restrict payment for "individual services" (§1155.32; and §1155.36 (1)). In the past, there were reports that the Department of Public Welfare refused to reimburse professionals for services to the parents or caregivers, even when they were done as an essential component of an evidence-based program. We want to ensure that no such penalties for delivering evidence-informed treatments will occur in the future. Often consultations are part of the total intervention done on behalf of a child. It makes little sense for the Department to require evidence-based services, and then refuse to reimburse for certain components of those evidence-based services.

The regulations should specify that payment will be made for all aspects of the evidence-based treatment program, even those components that involve direct consultations with parents, teachers, or other caregivers.

Medical Necessity Requirements

The regulations in Section §1155.32 (2) (v) states that reimbursement may not occur unless "the child, youth, or young adult is not progressing toward the goals identified in the

ITP." The word "progressing" also appears in §1155.33 (2) (v) and §1155.35 (4) (iii). Our concern is that word progressing might be interpreted by some to mean that the child be improving. However, this is not the standard for medical necessity specified in the medical assistance regulations. These regulations state that medical necessity is met if the service

> will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability . . . will or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability . . . [or] will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age (55 PA Code §11.01.21 (a)

Consequently, we recommend that the regulations should explicitly align payment with the medical necessity requirements specified in Pennsylvania's regulations and specifically allow for the payment of services that prevent the onset of a disorder, reduce the impact of a disorder or which help patients maintain functional capacity.

Evidence-Based Treatment

Section §1153.34 (7) states that reimbursement is conditioned on if "The IBHS agency has a current certification or licensure from the National certificate organization or entity that developed or owns the EBT provided or the EBT has been designated by the Department as a model intervention." However, the description of EBT in 5240.93 indicates a different standard for designation as a EBT provider as only requires that certification "if required to provide the EBT." We believe that the provisions in 1153.34 (7) are too narrow as many EBTs do not have a national certification process.

Transition Periods for Small Independent Practices

Although the proposed regulations provide a delay in getting a license for agencies that are currently licensed as psychiatric outpatient clinics, psychiatric partial hospitalization programs, family based mental health centers, or which are approved for ABA services (see for example, §5240.3), there is no similar delay permitted for small practice independent practices that currently provide these services. Furthermore, this lack of a transition period give priority to large organizations that already hold other licenses and disadvantages small businesses. Unless there is a reasonable time to get these licenses, thousands of children will have their services abruptly discontinued until these service providers get their new licenses to provide these services.

We recommend that the regulations allow a transition period for small businesses which are attempting to acquire the necessary agency licenses.

Administrative Burdens That Are Ambiguous or Do Not Further the Public Interest

The proposed regulations include several proposed regulations that are ambiguous or do not appear to promote the public interest such as those dealing with administrative directors, mandated safety plans, required post-charge contacts, the role of clinical supervisors, and ambiguities in the requirements for the IBHS facility license.

Administrative Directors

The regulations specify that the IBHS agency must have an administrative director and a clinical director. The responsibilities of the administrative director are in "the overall daily management of the agency," "setting work schedules," ensuring compliance with regulations such as "staff qualifications and training requirements," and "developing and monitoring the quality improvement plan for the agency" (§5240.11 (a)).

The administrative director must be a licensed mental health professional or have a degree in a mental health field or "public administration, business administration or related field" (§5240.12 (2)). We believe that these credentials are both too restrictive in that many of the functions do not require a graduate degree, such as setting work schedules, ensuring compliance with regulations, and the overall daily management of the agency. The phrase "overall daily management of the agency" is not defined but we assume it means such activities as paying bills, facility maintenance, bookkeeping, and so on. The regulations also require that the administrative director "shall dedicate a minimum of 7.5 hours each week" (§5240.11 (d)).

We know of no reason why a graduate degree is required for such functions. Nor do we believe it is appropriate for the agency to mandate the minimum number of hours per week that the administrative director must spend at the agency. We could easily imagine a scenario where an administrative director would spend, for example, 15 hours at an agency one week and 6 hour the next without any loss of the quality of services.

We recommend that the regulations allow more flexibility in who can be an administrative director and the hours that they work.

On the other hand, we find it problematic that the regulations give authority for quality improvement to administrative directors. Quality improvement which means, among other things, "assessment of the outcomes of services delivered and if ITP goals have been completed" (§5240.61 (a) (1) (iv)). The assessment of outcome services should not be an administrative or clerical chore, but, if it is done correctly, should be a professional service delivered with clinical and training issues in mind. Individuals with graduate degrees in public administration or business have not been trained to do this task responsibly. Any outcome project needs to be controlled or directed by a professional with advanced knowledge of mental health services, such as would be required by the clinical director.

We recommend that the assessment of outcomes of services should be a clinical issue handled by the clinical director of the agency.

Mandated Safety Plans

The proposed regulations state that an ITP must include a safety plan. It does not seem reasonable to require a safety plan for children who do not present a risk to harm themselves or others (See §5240.22 (d) (3)).

We recommend that safety plans should only be required when the professional has identified a threat to safety.

Methods of Post-Discharge Communications

There is a requirement for at least two telephone contacts within 30 days after discharge "to monitor the status of maintaining treatment progress" (§5240.32 (a) (4)). We have several concerns about this section.

First, we recommend that the regulations to have some flexibility here and allow other modes of communication, such as HIPAA secure emails if the parents or caregivers so desire.

Furthermore, the regulations permit no exceptions to this post-discharge requirement. Sometimes families are hard to get ahold of and do not return phone calls and others may be "unplanned discharges" and have discontinued treatment through excessive cancellations or no shows which implicitly indicated a desire to be left alone. In addition, some accommodation should be made for reasonable attempts without success to reach the family. The failure to allow some exception would mean that some providers will be making literally dozens of phone calls and even then, there would be no guarantee that the family would ever been contacted.

As a result, we recommend that the regulations permit some exception to this two-contact rule.

Flexibility in 15-day Face-to-Face Evaluations

The proposed regulations state that the 15-day "comprehensive face-to-face recommendations shall be completed by a behavior specialist or mobile therapist" (§5240.21 (a)) (underline added).

We recommend that the regulations include an option of having the agency's clinical supervisor conduct such evaluations. In small agencies it is sometimes necessary for clinical supervisors to step in during emergencies or unusual circumstances

Clinical Directors Acting as Supervisors

According to §524072 (1)), "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" (underline added).

This seems too restrictive and we recommend that the regulation should read that the clinical director may provide supervision if the agency employs 9 or less FTEs without the additional requirement that the staff does not include a qualified IBHS supervisor. We need no reason to restrict the flexibility of the agency in this manner.

IBHS Applications and Service Descriptions for Agencies

Section §5240.5 identifies the what must be included in the service description as part of the initial licensing process for IBHS providers. This includes "purpose of the service. . . [and] expected duration of the services and expected outcomes" ((1); "description of admission criteria" (6); "expected discharge criteria" (7); "exclusionary criteria" (8); and so on.

These requirements are confusing as they appear to ask applicants to describe duration of services, outcomes, admission and discharge criteria and so on for patients whom the agency has not yet seen. Perhaps these words or phrases have idiosyncratic meanings that are no apparent to the naïve reader. In any event, greater clarity is needed in describing what the Department expects in the service description.

Section §5240.4 (b) (Organizational Structure) states that the IBHS agency "shall notify the Department within 10 days of a change in the organizational structure of the IBHS agency." The problem here is that the term "organizational structure" is not defined. The term organizational structure should be defined.

We recommend that the regulations provide more clarity in what is wanted in the IBHS applications and service descriptions.

Range of Services to Children with a Diagnosis of Autism

The regulations appear to unfairly deny a wide range of appropriate services to children with diagnoses within the spectrum of autism disorders. While evidence strongly supports the use of applied behavioral interventions for children with autism, some children may have had traumas or other life issues that require more than just an applied behavioral analysis approach. For example, there is evidence that biofeedback can help some children with autism (some professionals view biofeedback as a form of ABA, but many do not, and we do not know of any department position on this issue). Furthermore, professionals would be put in a quandary if biofeedback for children with autism were to be designated as an evidence-based treatment (which professionals would be required to provide) yet prohibited from delivering it because it is not commonly viewed as part of applied behavior analysis.

We recommend that the regulations clarify that children diagnosed with autism disorders may receive services other than ABA services.

Failure to Address Options for Integrated Care

It is a major failing of these regulations that they do not address the options of delivering services in integrated care settings where physical and mental health needs could be address

concurrently. Patients in integrated care settings often have behavioral interventions as one component of their total care. They retain their original physical health diagnosis and continue under the treatment of the primary care or specialty physician even after they completed behavioral health services. To accommodate the realities of an integrated setting and their health care needs, these children should be able to receive behavioral health interventions upon the diagnosis of a physical disorder (and not necessarily a mental health disorder) and need accommodations in the record keeping, assessment process, and other area not covered by these regulations.

We recommend that the Department of Human Services write a section on regulations that permit the integration of medical and mental health services. It is true that the proposed regulations allow for a waiver process. However, the Department of Human Services has denied reasonable requests for waivers under the outpatient psychiatric facility regulations and we have no reason to think that they would be any more receptive to integrated care under these regulations as well. Consequently, we request that the Department explicitly create opportunities for integrated care in these regulations.

Other Questions or Requests for Clarification

Section §5240.41 (b) (3) states that the records must be "reviewed for quality at least every six months by the administrative director, clinical director or designated quality improvement staff. After initial review, subsequent reviews may be limited to new additions to the record since the prior review." It is unclear if this refers to clinical quality of service or billing accuracy as it relates to correspondence of the record to what was billed, or both.

If it is the former, then the proposed regulation seems excessive. Clinical directors should monitor records on an on-going basis. But requiring an additional or second review of records every six months seems unnecessary. At the most a second random review would be more than sufficient.

If it is the later then, the proposed regulation also seems excessive. Even Medicare's compliance guidance for individual or small group physician practices permits them to review "a randomly selected number of medical records. . ." It further states that "although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payor (i.e., Medicare, Medicare), or five to ten medical records per physician" (Department of Health and Human Services, Office of Inspector General, OIG Compliance Programs for Individual and Small Group Physician Practices, *Federal Register,* Vol. 65, p. 59427).

Section §5240.3 refers to Department-approved training. It would be helpful to know the standards or criteria that would meet department approval. Does this refer to trainings that could be used to fulfill the mandated continuing education requirements of licensing boards? Section §5240.13 (c) refers to the annual requirements for "professional licensing organizations." Does the phrase "professional licensing organization" to a licensing board. Licensing boards in Pennsylvania have two-year renewal cycles, not one-year cycles, so it was not clear what this section was referring to.

Section §5240.81 (b) (under staff qualifications) refers to a licensed psychiatrist as does Section §5240.11 (b) (2). Psychiatrists do not have a separate license in Pennsylvania. We recommend the use of another descriptor for psychiatric physicians.

Section §1155.32 requires that the autism spectrum disorder meet DSM or ICD diagnosis, but ICD is not mentioned in the definition section of autism spectrum disorders in §5240.2. We believe that the ICD should be referenced as well as the DSM in §5240.2.

Patients receiving group services must demonstrate progress within 45 days (§5240.106 (f) (2), and §1155.35 (4) (ii)) but patients receiving individual services must demonstrate progress within 90 days (§1155.32 (2) (iv). We question the discrepancy in the time lines needed to demonstrate progress. Although this may be an appropriate time for participants in the replacement for summer therapeutic activities programs, the preamble to the regulations state that group services could include other programs as well for "longer lengths of time that STAP" (p. 4767).

Professionals may only supervise nine full-time equivalent employees (see §5240.72 (d), §5240.82 (d), and §5240.102 (b)). We question whether this may be too restrictive. Anecdotal reports are that supervisors believe that they can supervise up to 12 full-time employees without a decline in the quality of services. An alternative may be to include the number of children being treated, and not the number of FTEs, as a standard for determining supervision.

The definition of individualized services refers to "intensive one-to-one therapeutic services" (p. 4765, definitions). We question the appropriateness of the word intensive in this context. According to Webster' Dictionary, *intensive* means "requiring or having a high concentration of a specific quality or element." Although the proposed regulations do not define the word intensive, it appears to require that individualized services will only be approved if they are concentrated heavily within a specific time or continue for a very long period of time. We believe that some children may benefit from short-term psychotherapy, however and we believe that the regulations should permit short-term psychotherapies when appropriate.

There are time requirements of 15 days for the individualized assessments (§1155.31 (2)) and EBT services (§1155.34 (2)) and 5 days for group services (§1155.35 (2)), but no time frame listed for ABA services (§1153.33 (2)). We suggest consistency in time frames for assessments.

The supervision requirements are for 30 minutes of direct observation every 3 months (§5240.72 (3)). This allows no variation according to the skill or experience of the supervisee. It is too little for novice employees and may be too much for more experienced employees.

Also, EBTs often require intensive supervision which may differ from the standards found in these regulations. We recommend that the Department reconcile this difference and allow agencies the opportunities to follow the supervision requirements of the EBTs even if they differ from those specified in these proposed regulations.

We note that clinical directors could include licensed social workers who have a "graduate degree that required a clinical or mental health direct service practicum" (5240.12 (b) (2)). While we appreciate the need to be flexible on credentials given the shortage of professionals willing to work in IBHS agencies, we believe that the requirement for only a graduate school practicum is not sufficient for the position of a clinical director and we recommend more experience before an LSW could become a clinical director.

The Department is demanding more and more from professional while keeping payment rates the same. For example, these regulations require post-discharge contact with families, supervision of staff, and staff training without offering any reimbursement for these activities. In addition, professionals will often consult with teachers, parents, or other caregivers even though such consultations are usually not reimbursed. While each of these activities can be justified, cumulatively they do place a strain on the ability of providers to hire and retain qualified staff. There is already a significant shortage of qualified individuals working within this system and this shortage is only likely to get worse unless reimbursement rates are increased. We ask whether the Department intends to increase reimbursement rates to ensure the viability of these programs.

Will the Department provide resources and trainings to help agencies meet all the requirements, such as information on evidence-based programs or where to get certification and training in those programs, or opportunities for agencies to work together to meet common educational needs?

The regulations fail to address the shortage of professionals in many areas of Pennsylvania (both urban and rural). The Department needs to make accommodations for agencies located in underserved areas who have no reasonable to qualified personnel. A waiver process is mentioned, but it does not specifically state that waivers would be made for under-served areas.

The regulations do not clarify how the roles of the assistant behavior specialist analyst and BHT-ABA differ. They should do this.

Section §5240.73 requires department approved training for licensed behavior specialists and for mobile therapist who are not licensed. We are assuming that licensed mobile therapists do not need any specific department approved training and that the training requirements of their licensing boards is sufficient. If so, the regulations should make this explicit.

The initial assessment and the ITP assessment must include many factors necessary to understand a child fully (see §5240.21 (b)). These requirements appear to follow closely the standards developed by Dr. Gordon Hodas which are widely used and adapted in Pennsylvania. We commend the Department for adopting these standards and urge them through policy to continue to support the assessment practices delineated by Dr. Hodas.

Summary

Thank you again for the opportunity to comment on these proposed regulations. We find many positive elements in these proposed regulations and commend the Department of Human Services for their work. Unfortunately, our initial review of these proposed regulations suggests that there are elements in these proposed regulations that violate existing Pennsylvania statutes and regulations, unfairly penalize small businesses, and are ambiguous and fail to give guidance to those impacted by the proposed regulations.

Specifically, these proposed regulations include problematic provisions including those that appear to:

- Restrict the scope of practice of licensed psychologists and unfairly deprive the citizens of Pennsylvania of highly competent services;
- Remove licensed professionals from the initial assessments and ITP updates;
- Allow interpretations of evidence-based treatment in a clinically contraindicated narrow sense that could deprive children of appropriate treatments;
- Lead to ambiguities regarding reimbursement for services such as

    Allowing children to go directly to the 30-day evaluation;

    Reimbursing for consultations to parents or teachers, especially if these consultations occur as part of an evidence-based program; and

    Ensuring that the Medical Assistance definition of medical necessity is followed.

    Remove the requirement that reimbursement may only occur if an agency has a national certification.

- Lead to uncertainty that children with a diagnosis of autism can receive services in addition to ABA if clinically appropriate;
- Risk creating a gap in services for children who are currently being treated by small-business independent psychology practices who do not currently hold a psychiatric outpatient clinic license or other license from the Department of Human Services;
- Impose administrative burdens that do not appear justified based on public interest. This includes

    Unnecessary restrictions on who can be an administrative director;

    Specifying minimum number of hours a week for an administrative director;

Mandating two post-discharge telephone conducts without allowing for other means of communications or clinically indicated exceptions;

Unnecessary restrictions on when a clinical director can be a supervisor; and

Ambiguity on what constitutes an organizational chart for a licensed Intensive Behavioral Health Agency; and

- Fail to address the option of delivering services in an integrated care setting.

Other issues that were raised include the need to:

- Clarify what constitutes an acceptable records review;
- Clarify what is meant by "professional licensing organizations;"
- Be more precise in describing an ASD diagnosis or the term psychiatrist;
- Clarify what constitutes a change in the organizational chart that requires notification of the Department of Human Services;
- Explain why group therapy should always require 45 days to determine the effectiveness of the service, especially if it is not a replacement of the STAP;
- Reconsider whether flexibility can be shown concerning the 9 FTE supervisee standard found in the proposed regulations;
- Consider if individualized services can be authorized even if they are short-term or as needed, as opposed to intensive as the proposed regulations now require;
- Identify a time frame for ABA evaluations, consistent with group or individualized services;
- Allow flexibility in direct observation according to skill level of the supervisee;
- Give priority to supervision requirements of EBTs; and
- Reconsider the educational and experiential background of LSWs who are clinical directors.

Consequently, we must oppose these proposed regulations as they are currently written. We are available to discuss these and any other concerns that you might have about these comments.

Rachael Baturin, MPH, J.D.
Director of Legal and Governmental Affairs
Pennsylvania Psychological Association

Samuel Knapp, Ed.D., ABPP
Director of Professional Affairs
Pennsylvania Psychological Association

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