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Sent: Friday, August 31, 2018 6:13 PM
To: PW, IBHS
Cc: Laughman, James; Tia Mann; Melissa Reisinger; Scott Suhring
Subject: IBHS Regulations-PerformCare -Feedback
Attachments: IBHS-PerformCare feedback.xlsx

PerformCare's feedback on IBHS Chapter 1155 & 5240 regulations is attached.

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	A	B
1	IBHS-PerformCare -Feedback	
2		
3	Chapter 1155	Comments - BH MCO and County roles are not addressed . Does not address what information needs to be submitted to the BH-MCO to determine medical necessity.
4	Regulation #	Regulations are not clear from an operational frame work.
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6	GENERAL PROVISIONS	
7	1155.1 Policy	Does paragraph (c) mean that no individual practitioners will be licensed for IBHS?
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9	1155.2 Definitions	Should written order be included here?
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11	SCOPE OF BENEFITS	
12	11.55 11. Scope of Benefits	
13		
14	PROVIDER PARTICIPATION	
15	11.55.21 Participation Requirements	
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17	11.55.22 Ongoing responsibilities of providers	
18		
19	PAYMENT FOR INTENSIVE BEHAVIORAL HEALTH SERVICES	
20	11.55.31 General payment policy	What is the definition of an "assessment" and a "written order"? Paragraph (d) appears to be more strict than 11.55.22 paragraph (d) which does not require a branch location or satellite location to be licensed - the requirement is for the agency to be licensed.
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22	11.55.32 Payment conditions for individual services	It is unclear what information is required for submission to Fee for Service or Behavioral Health-Managed Care Organization to determine medical necessity standards established by the Department under the Program Standard Requirements.
23		Can services be recommended per week as well?
24		What about Physician Assistant recommendation?;
25		are BHT prescriptions required to have a setting?
26		can prescriptions indicate a range, since it says "maximum number of hours"?
27		what constitutes a comprehensive face-to-face assessment and do they need to be submitted with re-authorization requests along with the written order for services?
28		If the recommendation needs to be made within the past 6 months, there is a chance the information could be quite outdated, is it possible to still request additional information (including updated clinical) prior to making an MNC decision?
29		*"If the behavior specialist provides individual services to a child diagnosed with autism spectrum disorder for the treatment of autism spectrum disorder, the behavior specialist shall have the same qualifications as a behavior specialist analyst that provides ABA services"* - Does this mean the person needs their BSL? Or is it a different set of requirements?
30		Does this section mean that psychological associates will no longer be able to complete a written order as it is not within the scope of practice to diagnose a behavioral health condition, or will it be allowable for a psychological associate to complete the written order for a psychologist/MD who is able to diagnose to sign? If no more psychological associates this would increase member's direct access to a psychologist, which could lead to improved recommendations and dx.
31		Does initiation of IBHS mean authorization or a first date of service?
32		(1) Is the parent/guardian required to participate? This would seem to be an important component of any face to face interaction that results in a written order for a Level of Care Service. In addition it is not clear what information is needed by the prescriber in order to determine clinically appropriate services for the written order. It would seem that a comprehensive assessment would drive the written order to assure that the person/child is prescribed the most clinically appropriate service, as well as that the written order meets the medical necessity standards established by the Department under the Program Standard Requirements. The regulations are vague on what drives the prescriber to issue the most clinically appropriate written order for service to assure the person/child treatments needs are met and not just a written order based the prescribers or parent/guardian wants a service that may in fact not meet the clinical treatment needs of the person/child.
33		(1) (iv) (A) What clinical information is required to support medical necessity for each service ordered? Regulation is not clear on specific format or type of information that is needed such as presenting problems, frequency, duration, intensity, setting, Current vs past presenting problems, etc. It would seem that basic clinical information would be required for a prescriber to issue a written order for a service to assure that clinical information drives the written order for each service to meet the treatment needs of the person/child.
34		(1) (iv) (B) Unclear what the duration is for each service, the time frame being requested and the minimum and maximum time frame that can be requested and authorization in the initial requests as well as for continued service request.

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35		(2) Face to face does not indicate who is required to participate in this assessment, it would seem that the Person/child, as well as the parent/guardian would be required to participate in order to obtain direct information from the person/child being assessed, as well as valuable input from the parent/guardian. Unclear how a comprehensive assessment can be completed if the parent/guardian is not required to participate in the face to face assessment. As well as there is not requirement for input from other systems, especially school input into the assessment if services are being prescribed in the school. In addition input from other treatment Providers. Also How is the face to face comprehensive assessment completed if more than 1 service is prescribed with different initiation start dates and Providers. There is no indication of required collaboration with different services on assessment.
36		(2) (vii) Does this include the Behavioral Health-Managed Care Organization?
37		(4) (vii) Who determines no longer clinically appropriate?
38		(6) Is any other clinical information and documentation required for continuation of services? Update assessment? Time frame and duration of the continued services? What information is need to support meets the medical necessity standards established by the Department under the Program Standard Requirements.
39		(7) How long is the written order valid as service may not be able to start based on staffing? Can the family wait until the same staff are available? Are re-start of service restricted to the original Provider?
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41	11.55.33 Payment conditions for ABA	It is unclear what information is required for submission to Fee for Service or Behavioral Health-Managed Care Organization to determine medical necessity standards established by the Department under the Program Standard Requirements.
42		Does this mean that ABA will now be authorized and delivered as a stand-alone service? Or will the "service" be the Behavior Specialist Analyst, Assistant Behavior Specialist analyst and/or the BHT-ABA?
43		(1) What is defined as a ABA service
44		(1) (iv)(A) What clinical information is required to support medical necessity for each service ordered? Regulation is not clear on specific format or type of information that is needed such as presenting problems, frequency, duration, intensity, setting, Current vs past presenting problems, etc. It would seem that basic clinical information would be required for a prescriber to issue a written order for a service to assure that clinical information drives the written order for each service to meet the treatment needs of the person/child.
45		(1) (iv) (B) Unclear what the duration is for each service, the time frame being requested and the minimum and maximum time frame that can be requested and authorization in the initial requests as well as for continued service request.
46		(2) Face to face does not indicate who is required to participate in this assessment, it would seem that the Person/child, as well as the parent/guardian would be required to participate in order to obtain direct information from the person/child being assessed, as well as valuable input from the parent/guardian. Unclear how a comprehensive assessment can be completed if the parent/guardian is not required to participate in the face to face assessment. As well as there is not requirement for input from other systems, especially school input into the assessment if services are being prescribed in the school. In addition input from other treatment Providers. Also How is the face to face comprehensive assessment completed if more than 1 service is prescribed with different initiation start dates and Providers. There is no indication of required collaboration with different services on assessment.
47		(2) (vii) Does this include the Behavioral Health-Managed Care Organization?
48		(4) (vii) Does this include the Behavioral Health-Managed Care Organization?
49		(6) Is any other clinical information and documentation required for continuation of services? Update assessment? Time frame and duration of the continued services? What information is need to support meets the medical necessity standards established by the Department under the Program Standard Requirements.
50		(7) How long is the written order valid as service may not be able to start based on staffing? Can the family wait until the same staff are available? Are re-start of service restricted to the original Provider?
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53	11.55.34 Payment conditions for EBT	Does this mean every IBHS agency must have at least one EBT that they are certified in or that they develop their own model and get it approved by the Department? Or is it saying that *IF* they choose to do these things then they must be licensed or certified by the EBT entity?
54		It is unclear what information is required for submission to Fee for Service or Behavioral Health-Managed Care Organization to determine medical necessity standards established by the Department under the Program Standard Requirements.
55		(1) What clinical information is required to support medical necessity for group service ordered? Regulation is not clear on specific format or type of information that is needed such as presenting problems, frequency, duration, intensity, setting, Current vs past presenting problems, etc. It would seem that basic clinical information would be required for a prescriber to issue a written order for a service to assure that clinical information drives the written order for each service to meet the treatment needs of the person/child.
56		(2) Face to face does not indicate who is required to participate in this assessment, it would seem that the Person/child, as well as the parent/guardian would be required to participate in order to obtain direct information from the person/child being assessed, as well as valuable input from the parent/guardian. Unclear how a comprehensive assessment can be completed if the parent/guardian is not required to participate in the face to face assessment. As well as there is not requirement for input from other systems, especially school input into the assessment if services are being prescribed in the school. In addition input from other treatment Providers. Also How is the face to face comprehensive assessment completed if more than 1 service is prescribed with different initiation start dates and Providers. There is no indication of required collaboration with different services on assessment.
57		(2) (vii) Does this include the Behavioral Health-Managed Care Organization?
58		(4) (viii) Does this include the Behavioral Health-Managed Care Organization?
59		
60	11.55.35 Payment conditions for group services	The requirement that an update be completed when meets an ITP goal (2, iv) may not be appropriate to all EBTs
61		Will Group services through IBHS be considered a separate service code and require authorization? Or can any individual approved for another IBHS service attend group when/if clinically appropriate?
62		What is defined as Group services?
63		(1) What clinical information is required to support medical necessity for group service ordered? Regulation is not clear on specific format or type of information that is needed such as presenting problems, frequency, duration, intensity, setting, Current vs past presenting problems, etc. It would seem that basic clinical information would be required for a prescriber to issue a written order for a service to assure that clinical information drives the written order for each service to meet the treatment needs of the person/child.

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64		(2) Face to face does not indicate who is required to participate in this assessment, it would seem that the Person/child, as well as the parent/guardian would be required to participate in order to obtain direct information from the person/child being assessed, as well as valuable input from the parent/guardian. Unclear how a comprehensive assessment can be completed if the parent/guardian is not required to participate in the face to face assessment. As well as there is not requirement for input from other systems, especially school input into the assessment If services are being prescribed in the school. In addition input from other treatment Providers. Also How is the face to face comprehensive assessment completed if more than 1 service is prescribed with different initiation start dates and Providers. There is no indication of required collaboration with different services on assessment.
65		(2) (vii) Does this include the Behavioral Health-Managed Care Organization?
66		(4) (vii) Does this include the Behavioral Health-Managed Care Organization?
67		(6) Is any other clinical information and documentation required for continuation of services? Update assessment? Time frame and duration of the continued services? What information is need to support meets the medical necessity standards established by the Department under the Program Standard Requirements.
68		(7) How long is the written order valid as service may not be able to start based on staffing? Can the family wait until the same staff are available? Are re-start of service restricted to the original Provider?
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70	11.55.36 Covered services	
71		
72	11.55.37 Limitations	(2) Within 60 days prior to discharge or 60 days after discharge. Unclear if this addresses services to be provided while person/child in residential as part of discharge transition or are service post discharge.
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74	UTILIZATION REVIEW	It is unclear what information is required for submission to Fee for Service or Behavioral Health-Managed Care Organization to determine medical necessity standards established by the Department under the Program Standard Requirements.
75	11.55.41 Scope of claims review procedures	It is unclear what information is required for submission to Fee for Service or Behavioral Health-Managed Care Organization to determine medical necessity standards established by the Department under the Program Standard Requirements. What is the initial and continued stay utilization management requirements of Providers.
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77	ADMINISTRATIVE SANCTIONS	
78	11.55.51 Provider misutilization	
79		
80	5240.74, 5240.84, 5240.91, 5240.104 - Service initiation	
81		What specifically will need to be submitted to the Behavioral Health-Managed Care Organization, and when, in order to obtain prior authorization for IBHS?
82	5240.31 and 5420.32 - Discharge	
83		will providers be required to submit any type of request to the Behavioral Health-Managed Care Organization in order to obtain approval for the provision of services for up to 90 days after discharge?
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85	Chapter 5240	
86	Regulation #	Comments - Behavioral Health-Managed Care Organization and County roles are not addressed
87		
88	GENERAL PROVISIONS	
89	5240.1. Scope	
90		
91	5240.2. Definitions.	
92		What about a definition of written order?
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94	5240.3. Provider eligibility.	
95		Paragraph (b) indicates that an agency can provide IBHS without being in compliance with the act which presents the potential/opportunity to not follow the fidelity of the model Paragraph (c) as written provides an exception to obtaining an IBHS license that should be eliminated - it creates a situation in which IBH services could be conducted outside the fidelity of the model and the license. Paragraph (d) holds ABA agencies to a higher standard than non-ABA agencies; the standard should be the same to protect the fidelity of the model and the license.
96	5240.4. Organizational structure.	
97		
98	5240.5. Service description.	Unclear if service description has to be submitted to the Behavioral Health-Managed Care Organization for review and input prior to submission to Department. Role of Behavioral Health-Managed Care Organization and County in review of service description prior to submission to Department and approval by Department.
99		Isn't "admission criteria" defined in Appendix S/T?
100		(a) (5) County letters of agreement required to be submitted with service description? Behavioral Health-Managed Care Organization agreement required?
101		(11) Training requirements for treatment modalities and EBP ? Staffing requirements for those providing treatment modalities and EBP? How will fidelity be maintained for treatment modalities and EBP? Outcome measurements for treatment modalities and EBP?
102		
103	5240.6. Restrictive procedures.	

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104		(2) (b) Requirements that staff are trained before implementing any manual restraints.
105		(2) (f) Require review of ITP after every use of a manual restraint to determine if revisions are needed, as well as require a restraint reduction plan be added to ITP after the first use of a manual restraint and updated after every use of a manual restraint .
106		(g) Prior training before implementing the use of a manual restraint.
107		
108	5240.7. Coordination of services.	(a) Role of IBHS coordination with Behavioral Health-Managed Care Organization / Role of Role of IBHS coordination with other IBHS agencies.
109		(f) Define group services. Also group service should be held to the same coordination of service expectations and standards for quality of member care.
110	STAFFING	
111	5240.11. Staff requirements	
112		
113	5240.12. Staff qualifications	
114		
115	5240.13. Staff training plan	
116		(3) d) include requirements for documentation to confirm training.
117		(7) Process for Department approval of training.
118		
119		
120	SERVICE PLANNING AND DELIVERY	
121	5240.14. Criminal history checks and child abuse certification	
122		
123	5240.21. Assessment.	Does this need to be submitted to the Behavioral Health-Managed Care Organization along with re-authorization requests?
124		(8) (e) How often are update required if 1 to 7 do not apply?
125		(8) (e) (6) How is a crisis event defined
126		(8) (e) (7) Does this include the Behavioral Health-Managed Care Organization?
127		
128		
129	5240.22. Individual treatment plan	Does this need to be submitted to the Behavioral Health-Managed Care Organization along with re-authorization requests?
130		(d) (3) Transition plan for what? Next Services? Discharge ? Rationale for transition plan is not clear.
131		(f) If progress is being made then no updates are very required? If minimal progress is being made then no updates required?
132		(f) (5) Define crisis event
133		(f) (7) Does this include the Behavioral Health-Managed Care Organization?
134		
135	5240.23. Service provision	
136		
137	DISCHARGE	
138	5240.31. Discharge	Add section that discharge is required if non-adherence to treatment and ITP by the person/child. Adherence is integral to treatment and to assure taxpayer dollars are not wasted
139		Add section that discharge is required if non-adherence to treatment and ITP by the parent/guardian. Adherence is integral to treatment and to assure taxpayer dollars are not wasted
140		What if provider no longer has capacity when service re-initiation is requested after discharge?
141		Does this include any type of discharge?
142		Clarify "complete at least two telephone contacts" - does this include only connecting with member/family or attempts to contact, how many UTCs before provider can cease attempts, should there be a standardized expected way that these discharge contacts occur so that all providers do in the same manner? What if d/c do an inability to adequately serve the member or danger to staff, and family calls to reinitiate?
143		When re-initiating services after a d/c, is the level (e.g., number of hours; settings) of treatment at the provider discretion or do they revert to the most recent written order and must provide the services the member received upon discharge? And if this would be too intensive, does the provider have the discretion to adjust?
144		Would there be situations where the provider did not have to provide discharge boosters (e.g., member was d/c due to nonadherence to treatment by the person/child? Non-Adherence of parent/guardian? ; member a danger to staff)? And if this is the case is there a process that would outline how the provider ensures member receives treatment?
145		(a) (2) Is discharge required if no progress and person/child & parent/guardian want to continue? Who determines if parent/guardian do not agree to discharge?
146		(a) (3) Include other clinical services are in place to provide continuity of care
147		(a) (5) (b) Require that discharge information if provided to the next level of care service for continuity of care. Require that discharge information be provided to Behavioral Health-Managed Care Organization for continuity of care and quality management of care.
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149	5240.32. Discharge summary	
150		
151	RECORDS	
152	5240.41. Individual records	
153		
154	5240.42. Agency records	
155		
156	5240.43. Record retention and disposal	
157		
158	NONDISCRIMINATION	
159	5240.51. Nondiscrimination	
160		
161	QUALITY IMPROVEMENT	
162	5240.61. Quality improvement requirements	
163		There is no inclusion of the BH MCOs in the QI process.
164	INDIVIDUAL SERVICES	"The INHS agency is required to prepare a report of the findings of the annual review..." Consider having some standardized measure for comparison b/w agencies. This can be two to three criterion that will allow members to make some judgement as to the quality of clinical services provided. If each agency QI report is dramatically different there would be limited basis for comparison to occur. Also in this section should the use of objective, quantifiable outcome information be mentioned and highlighted? Developers may wish to develop a template of the necessary information to be included (and providers can exceed this if desired) in order to provide relevant and accurate information.
165		There are no requirements for the Assessment or the ITP developed for a an individual without ASD or Non ABA services. There should be minimum standards for Induvial services that do not fall under BA or EBP to assure quality of treatment with this population
166	5240.71. Staff qualifications	
167		"Behavior specialists can assess the behavioral needs of children..." would it be helpful to further define "behavioral goals or would this be more appropriate in SD from provider. Is it rehabilitation and habilitation now? If so, I think there should be guidance rather than a grey area. Would communication be ok for a goal developed by a Behavioral specialist or only by a BCBA? What about functional improvement?
168		"BHTs support children's...young adults' problem solving skill development" - Consider "...young adults' identified area of need that will be treated via skill development". Or something similar. This is due to the many evidence based problem-solving treatment packages and to reduce confusion that this is related to particular treatment. Also problem-solving is rather ambiguous.
169		(d) A BHT
170		
171		
172	5240.72. Supervision	
173		
174	5240.73. Staff training requirements	
175		
176	5240.74. Individual services initiation requirements	Role of medical necessity determination prior to initiation of induvial services is not addressed.
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178		
179	5240.75. Individual services provision	
180		(a) Does not indicate the role of the Behavior Specialist developing the ITP if there is no Mobile Therapist on case
181		(a) (6) requirement should include the review of the clinical outcomes with the mobile therapist and the BHT.
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183		
184	APPLIED BEHAVIORAL ANALYSIS	
185	5240.81. Staff qualifications	
186		
187	5240.82. Supervision	
188		
189	5240.83. Staff training requirements	
190		

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191	5240.84. ABA initiation requirements	
192		
193	5240.85. Assessment	
194		
195	5240.86. Individual treatment plan	
196		
197	5240.87. ABA services provision	
198		
199	EVIDENCE-BASED THERAPY	
200		
201	5240.91. EBT initiation requirements	
202		
203	5240.92. Assessment and individual treatment plan	
204		
205	5240.93. EBT requirements	
206		
207	GROUP SERVICES	
208	5240.101. Staff requirements and qualifications	
209		
210	5240.102. Supervision	
211		
212	5240.103. Staff training requirements	
213		
214	5240.104. Group services initiation requirements	
215		
216	5240.105. Assessment	
217		
218	5240.106. Individual treatment plan	
219		Is this separate from the individual IBHS treatment plan or should group services goals be included in the ITP?
220	5240.107. Group services provision	
221		How many Members can be served in a single group?
222	5240.108. Requirements for group services in school settings	
223		
224	WAIVERS	
225	5240.111. Waivers	