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From: Kate Pompa <Kate.Pompa@wfspa.org>
Sent: Friday, August 31, 2018 11:02 AM
To: PW, IBHS
Cc: Kate Pompa; Pam Weaver; Christian-Michaels, Stephen
Subject: Comments/Questions re: Proposed IBHS Regulations
Attachments: Wesley Family Services Comments-Proposed IBHS regs.docx

Good Morning,

Please find attached comments/questions re: the Proposed IBHS Regulations on behalf of Wesley Family Services. We appreciate the ability to partner with you regarding these proposed regulations and look forward to future workgroups as they are scheduled. Please feel free to reach out to me with any questions or concerns.

Thanks so much,

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wesley family services

Wesley Family Services Comments/Questions re: IBHS Draft Regulations 1155 and 5240

1. On page 11/12 of the face sheet for filing document it states that in order to qualify to be a BHT you need a BA degree with 1 year of full time experience. In the regulations under 5240.71 (b) (1) it states that BHTs need a BA degree but does not indicate an experience requirement. These are contradictory- which is correct? We are hoping the latter, as the addition of the 1 year experience to a BA degree would be difficult to recruit.

2. There is reference throughout the documents to a written order (within 6 or 12 months) that must be completed to initiate services.
    a. There are a variety of expectations of a written order outlined in 1155.32 Payment Conditions for Individual Services and 1155.33 Payment Conditions for ABA (1)-(4) including maximum number of hours of each service per month, settings in which it can be provided, etc. Would Best Practice Evaluation (done currently in BHRS) count? Would a prescription letter (done currently in Enhanced Partial Hospitalization and CSBBH teams, which are BHRS exceptions) count?
    b. With the written order prescribing a maximum hour amount and settings where the service may be provided, we believe that this could set the licensed clinician doing the assessment up for failure, particularly if the assessment concludes that a lesser amount of services is needed and/or if a setting that was identified does not require services (such as a school, etc.) Currently, in BHRS there is often a struggle between prescriber and provider in that the prescriber may indicate a high number of hours that the provider feels is unnecessary and this discrepancy causes friction with the family.
    ****It is suggested that the written order eliminate 1155.32 and 1155.33 (4) (ii) and (iii) and rather just recommend an assessment for IBHS, that way the licensed professional completing the assessment can have the ability to recommend hours and settings with the family.** Lastly, if this is not able to be changed- what happens if there is a discrepancy between what the written order indicates and what the assessment indicates and the family wishes to dispute?
    c. Could a representative with an LPC or LCSW from an agency providing IBHS write the initial and continued service written orders or does it need to be an independent entity? Likewise, if the Behavior Specialist on the case is an LPC or LCSW could that clinician write the order for continued service?

3. There is reference throughout the document to a BHT and a BHT with a competency in ABA certificate from the PA Certification Board.
    a. What does this certification entail? What is the cost? What is the length of time to achieve it?
    b. If current clients are receiving ABA from a Behavior Specialist who is not certified but intends to become certified- will that client lose that clinician until they are able to achieve this certification or will there be a grace period? A grace period for the Behavior Specialists (similar to how you indicated 18 months for the BHT) would be very important so that clients do not go unstaffed or without services for a period of time.

4. Can you clarify how the Behavior Specialist Analyst works with the Assistant Behavior Specialist Analyst?
    a. Does a client receive one or other, or can they receive both?
    b. Who determines which one a client gets?
    c. If there are two on a case- how often does the BSA need to be on-site with the ABSA or can the ABSA function independently with just the BSA assisting with treatment planning, etc.

5. In 5240.32 Discharge Summary there is reference to post discharge phone calls that must occur in the 30 days following discharge.
    a. What if the family discharges unplanned? Could the language in 5240 (4) be changed to "documentation of at least 2 telephone contact attempts"?
    b. Is it possible that these phone calls could be billable?
    c. Will providers be able complete discharge summaries prior to these calls or do they need to be held until these calls are completed?

6. In 5240.41 Individual Records (b) (3) it states that every record shall be reviewed for quality at least every six months by the administrative director, clinical director or designated quality improvement staff. For large agencies, it would be very difficult to get every single chart, twice per year without significant increases in infrastructure. Currently, there is no stipulation in BHRS for these reviews, however, our agency reviews 10% per year for our own quality plan. We feel that there should be a sample size identified per year with regard to these reviews that does not encompass every single chart.

7. In 5270.41 Individual Services Staff Qualifications (4) (b) it states that Behavior Specialists who provide individual services to children with ASD for the treatment of ASD shall meet the qualifications for a behavior specialist analyst in 5240.81 (c). Why is this requirement in place if the Behavior Specialist is not delivering ABA? Suggestion for this to be removed from the Individual Services section.

8. In 5240.72 Supervision and 5240.82 Supervision there is a large increase in the number of supervision hours needed by staff at all levels from what is currently provided in BHRS. While we believe that additional supervision is positive and necessary, the amount of this increase from the current expectations in BHRS seems cumbersome, particularly the requirement in (2) and (3) for one individual face to face session a month for each IBHS staff and thirty minutes of direct observation of services being provided by each IBHS staff person every three months. Recommendation would be to go with one or the other, but not both.
    ****Because of the large increase in personnel costs that increasing this supervision will require would it possible to bill supervision, particularly if it is done on site in a family's home? This would be similar to how Assessment and Assistance currently works in BHRS and would be tremendously effective in providers being able to allocate resources to fulfill this requirement to fidelity.**

9. In 5240.5 Service Description (a) (1)-(12) outlines the items that must be included in a service description. As discussed in the IBHS workgroup, a positive of moving from bulletin oversight to licensed regulations was the elimination of the need for lengthy service description processes. Could the

expectation be similar to outpatient where we have program descriptions, instead of lengthy service description documents?

10. In 5240.71 Staff Qualifications (a) under qualifications of a behavior specialist, there is no mention of an LPC, LCSW, LMFT or LSW. Do they qualify to do this position? In (a) (3) it states that a graduate degree in psychology, counseling, etc and one year full time experience would qualify. Because LPCs, LCSWs and LMFTs have a 3000 hour supervised working requirement they would qualify. Also, a BSL qualifies in (a) (1). Suggestion would be to add LPC, LCSW, LMFT to (a) (1) as these licenses are much more stringent than a BSL and require 3000 hours of direct supervision. This would eliminate the need for providers to do education and work experience checks on those that have one of these licenses.

11. Will Family Focused Solution Based Therapy (FFSB) be included in these regulations? If so would it fall under individual services or evidence based services? If an agency has more than one 'individual services' offered eg. FFSB and what is currently BHRS will two different service descriptions need to be written?

12. In Group Services 5240.105 Assessment and 5240.106 Individual Treatment Plan, assessment and treatment planning is required and expected. In the current system, for many site based social skills programs these functions are not reimbursable which is difficult to manage. Under these regulations will assessment and treatment planning be items that can be billed?

13. On page 15 (29) (c) of the regulatory analysis it states that this regulation is proposed to be in final form by 3rd quarter of 18. This is very fast. Will there be an adequate time period built in for current providers to apply for and receive this license? (29) (f) states that agencies operating under an outpatient psychiatric clinic, psychiatric partial hospitalization program or a family based mental health license must obtain the IBHS license upon the expiration of that current license. Will there be grace periods if the regulations are promulgated within 180 days of the license expiration? If an agency is going to provide multiple services in IBHS, it might not be realistic to switch all of those over in less than 180 days.

14. After reading and understanding the elimination of the best practice evaluation and ISPT processes, it seems that MCO oversight and management might look similar to a commercial plan and/or an outpatient model. Will there be streamlined processes across PA for MCOs? Will there be any safeguards against them imposing additional processes? This has been the case with the current BHRS system, where each county has their own rules/regulations and has caused difficulty in providing the service to a wide geographic region.

15. On page 11 (24) (b) of the regulatory analysis form it states that "Because it is anticipated that the cost of the new paperwork and administrative requirements will be offset by the elimination of other paperwork and administrative requirements, no additional costs are anticipated as a result of the changes to current practices." With increased Record Keeping, Quality Improvement, Supervision, Staff

Training, Discharge Summary requirements coupled with higher recruitment costs due to needing additional certifications at every level, the increased cost to providers will be significant. While elimination of the ISPT process and Service Description submissions will be helpful, it will not in any way offset the costs of implementing these regulations. With a flat lined budget will it be possible to implement these regulations and provide the MCOs the sufficient funding to increase rates and provide adequate reimbursement to providers for offering these services?