14-546-77 3209

Champa, Heidi

From:	Chris Tabakin <CTabakin@accessservices.org>
Sent:	Tuesday, September 04, 2018 1:46 PM
To:	PW, IBHS
Cc:	Pride, Tara; 'gdigirol@pahousegop.com'; Whitney Smith; Audra Nihart; Sue Steege; Rob Reid; Andy Ward; Rob Reid
Subject:	Regulation No. 14-538 Comments
Attachments:	Access Services IBHS Regulations Comments Final 9-4-2018.pdf

Greetings,

On behalf of the Access Services Executive Management, thank you for the opportunity to provide comments on the proposed rulemaking. Please find comments on the proposed rulemaking for the Department of Human Services 55 Pa. Code Chapters 1155 and 5240.

We have copied in Honorable Gene DiGirolamo, Chair of the House Human Services Committee.

Thank you very much.

Best,

M. Christopher Tabakin, M.S.

Director of Quality and Compliance
Compliance and Privacy Officer
215-540-2150 ext. 1326

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Creating better ways to serve people with special needs
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"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
– Maya Angelou

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3209

9/4/2018

Attention: Tara Pride

Tara Pride
Bureau of Policy, Planning and Program Development
Commonwealth Towers11th Floor, P.O. Box 2675
303 Walnut Street
Harrisburg, Pennsylvania 17105

Via electronic mail submission at: RA-PWIBHSpa.gov and tpride@pa.gov

RE: Regulation No. 14-538

Dear Ms. Pride:

Access Services, Inc. appreciates the opportunity to comment on the proposed rulemaking for the Department of Human Services 55 Pa. Code Chapters 1155 and 5240.

For over 30 years, Access Services has been developing innovative ways to provide support services for individuals with special needs, including those with behavioral and mental health needs, in Southeastern Pennsylvania. Today, we are a large non-profit organization of about $34 million in annual revenue, with over 600 staff members and contractors operating in eleven counties within Pennsylvania. We provide services for close to 5,000 people with intellectual and developmental disabilities, and/or mental health needs. Our mission is to empower and serve people in need of specialized supports by providing innovative services that improve their ability to live fulfilling lives in the community.

Regulatory Analysis Form/Summary of Feedback:

We would like to commend the department for the inclusion of several areas proposed that we feel will benefit the service recipients in the systems, and providers of those services. By developing codified minimum expectations concerning health and safety we can help to further ensure the consistently safe and effective provision of services throughout the state and system. Further, by developing a license mechanism that is separate from operation of an outpatient clinic, as well as clear standards and opportunities around evidence based therapies, we believe that the access to a wider array of impactful holistic approaches to treatment will be made increasingly available and benefit individuals receiving services and supports. Finally, some efforts appear to have been made to streamline processes and documentation expectations, which may, with some incorporated recommendations made below, result in more effective service delivery while reducing certain administrative burdens of providers of services and supports. Where applicable the comments outlined explicit to certain sections will identify areas we support and feel are positive inclusions in this draft.

While we feel several areas are identified for positive improvements in this draft regulatory language, we also feel there are areas of concern. Where applicable the comments outlined below explicit to certain sections will identify areas we feel are in need improvement, change, or deletion from draft language. The following is a summary of comments identified from the regulatory analysis section, as well as recommendations.

Background:
Throughout these proposed regulations, the wording is such that it appears to assume that all those who provide the services are staff, employees of the agency, and not contractors. Currently, many organizations engage contractors to provide these services. Access Services is one such provider. These proposed regulations need to make clear that the regulations apply in circumstances both with staff employed by and agency, but also make clear the recognitions that these services may also be provided by contactors, which establish different expectations from the Department of Labor standpoint under which we as the contracting agency must treat the contractors not as staff, but as contractors. The limitations and expectations in both of these circumstances are different and must be clearly recognized and identified throughout these proposed regulations. If it is the intent of these regulations to only apply to staff employed by the agency, this would be a dramatic shift in the system and must be fully evaluated as to the impact to agencies which currently utilize contractors including operational and fiscal impacts of which both would be significant.

Recommendation(s):
Revise all language within the draft regulations to clearly communicate the applicability to either staff employed by an agency, or contractors providing the services. If the intent is to make regulations only applicable to staff employed by an agency, a full system and provider impact analysis must be completed to identify the operational and especially fiscal impacts and we recommend that the promulgation of the proposed regulations be delayed until such analysis is completed.

Background:
"Finally, providers will benefit from the proposed regulations because the regulations clarify that staff do not have to repeat training requirements when working for more than one agency or changing employment."

The assertion that this will reduce training requirements and as such costs associated with those requirements is inaccurate in our opinion. For two decades funding for these types of programs have not kept up with cost of living increases which has resulted in more restricted access to services as providers discontinue programs. It is difficult to assess the regulations without knowing what the funding portion of this is going to be including rate setting methodology and productivity with consistency across managed care organizations (MCOs). We fully support the idea of quality, higher qualifications for staff and increased supervision. The concern is that these requirements do not equate to an increase in funding, which will over time result in less access to services for those with the highest need.

Though it is possible that an agency could decide to not provide provider-specific training if a staff or contractor, most agencies would still be interested in providing their own provider-specific training. With a desire for best practices to be implemented, as well as to help establish the provision of services within the context of the organizational approach and culture for consistency, the provision of training regardless of previous training by another agency is still an expectation our organization would employ. We would not realize any cost savings based on the proposed change, and we feel that for the clinical and service-provision integrity that training by Access Services would still be necessary.

Recommendation(s):
Revise the regulatory analysis to more accurately reflect that though this could be an option for providers around training that for best practices and service provision integrity providers will likely still provide their own training. As such, the costs associated with the implementation of these draft regulations should be identified and accounted for in the analysis. As a general comment, based on the draft, we feel there will be significant cost to providers and the system which are not reflected accurately in the analysis and should be considered more transparently and realistically.

Background:
"The Department convened a workgroup consisting of approximately 75 individuals representing an array of stakeholders to provide input into the development of Chapter 5240, the proposed licensing regulations." Our internal workgroup within Access Services included staff who participated with Rehabilitation and Community Providers Association (RCPA) in a workgroup to evaluate these proposed regulations. Anecdotally it was shared by members of that group that the department workgroup indicated above from the regulatory analysis form did come up with recommendations collaboratively. However, it was noted that many of the areas and recommendations are not

reflected in this final draft proposed regulation. Though the regulatory analysis form indicates a multidisciplinary stakeholder group was engaged, it appears to not reflect the fact that the outcome represented in these draft proposed regulations in some cases do not reflect the actual work and agreement of that group.

Recommendation(s):
Review the work of the previous stakeholder groups and compare the outcomes to those actually represented in these draft proposed regulations and revise accordingly to identify where they do not coincide in an effort to be more accurate and transparent in the process for the public and consideration by the Independent Regulatory Review Commission (IRRC).

Background:
"Some additional costs to IBHS agencies are expected as a result of the proposed regulations, but these costs are expected to be offset as a result of expected savings and the opportunity to serve more children, youth and young adults. IBHS agencies may need to hire additional or different staff to become licensed, which could result in an increase in costs for the agency (see # 19 for additional information). However, there is expected to be a decrease in staff training costs because the proposed licensing regulations clarify that staff do not need to repeat initial or annual training when changing employment or working for more than one IBHS agency."

and

"The proposed regulations benefit IBHS agencies because they include standards for licensure and the delivery of IBHS, clarify the training requirements for staff changing agencies, and eliminate the requirement for an interagency service planning team (ISPT) meeting prior to the initiation of services. The proposed regulations also allow IBHS agencies to submit to the Department for review the IBHS agency's service description as part of the initial licensing application package. This will streamline the process for providers. The service description can include all IBHS that the agency would like to provide, which will eliminate the need for providers to submit multiple service descriptions."

and

" IBHS agencies are not required to pay for a staff person to obtain certification, but may have to increase salaries to retain qualified professionals which may impact agency cost. The Department expects that increased costs as a result of the staffing requirements will be offset as a result of IBHS agencies saving money by decreasing training costs and increasing revenue by being able to serve more children, youth and young adults."

and

"IBHS agencies may experience a decrease in staff training costs because the proposed licensing regulations clarify that staff do not need to repeat initial or annual training when changing employment or working for more than one IBHS agency."

These sections include considerable conjecture and assumption concerning any costs or time savings. The suggested offsets of costs vs. revenue potential generation is based fully on conjecture and should not be utilized in and attempt to justify that this is somehow cost neutral. As noted above, the assertion that the change in training requirements will streamline or reduce costs is inaccurate to the functional reality that providers will engage in concerning training. It is expected that more staff would be hired or contractors contracted with for service provision based on the changes and that the cost will be increased without any offset in training cost reduction a noted above.

Also, as clearly articulated below in the department's response, it is not possible to quantify the staff (contractors) costs. As such it is inappropriate to note any costs savings or assert only that these regulations would essentially be cost neutral and not make some assumptions on the actual potential for increased cost overall and identify this for the public, IRRC and legislature. In the table it lists basically no increased costs, we feel this is inaccurate and does not give a clear and transparent picture to the stakeholders including public as tax payers, providers of service, the IRRC and legislature.

(19) "In order to become licensed to provide IBHS an agency may need to hire additional or different staff, which could result in an increase in costs for the agency. **It is not possible to quantify the costs related to staffing requirements because the Department does not know which staffing options an IBHS agency will utilize."**

The assertion that by submitting one comprehensive service description will result in streamlining or reduced costs does not take in to account any of the changes and inclusions in this submission. It appears that there may be cost associated based on time necessary to include all the information in the description, as well as licensing each service location, and at absolute best, it would be cost neutral and not savings.

Recommendation(s):
Review in a more comprehensive and accurate way the potential costs associated with the draft proposed regulations and indicate as such a more accurate review of the impact can be completed by all stakeholders including the public as tax payers, providers of services, the IRRC, and legislature.

Areas of proposed improvement to system supported:

The following areas of proposed changes we feel are excellent improvements to the operation of the system and will promote the enhancement of clinical practices and treatment opportunities.

Recommendation:
Final rulemaking should maintain the following currently proposed changes:

- Codifying the basic requirements to maintain the health, safety, and welfare of service provision.
- Inclusion of expectations and limitations concerning restraints.
- Inclusion of clear ability and requirements for evidence based practices.
- More consistent training expectations for (TSS) BHT's.
- ABA as a separate service with its own parameters.

Areas of proposed changes with recommended changes by individual section/area:

General Provisions:

Area: Definition of ABA is broad-language is limiting; meaning that ABA is the only recognized treatment service.

Background:
The definition of ABA is broad and encompasses more than just the program defined for ASD clients. Additionally, the way the services are structured puts a heavy focus on this treatment modality across the Individual and ABA IBHS programs. Since Individual Services will have a large mental health focus, and ABA is a separate program, is there a way to have structure to the Individual BHT services without tying it so directly to ABA?

Recommendation:
We would like assurances that the service description process will be efficient and collaborative; technical assistance will be offered to improve the length of the review process.

Area: Staffing

Background:
The following are areas with unclear expectations and with questions concerning the intent of the proposed regulations.

- Clinical Director for Individual Services --can this include the Licensed Behavior Specialist (LBS) credential? Can the clinical director carry a caseload?

- Department approved training-what is the process? By whom?

While we agree the RBT training and competency assessment process create a strong clinical foundation, we fear that the logistics of requiring the credential itself may be prohibitive to sustainable practice.

Recommendation(s):

- The Administrative Director can possess a Bachelor's Degree and experience required. We believe that it isn't necessary to have a master's level individual providing day-to-day management.
- Individual staff training plan should delete date of hire language. We believe it to be sufficient that each training plan is updated annually.
- Propose that the 7.5 hour per week standard be removed so there is more flexibility for manager to put time in where it is most needed.
- Can the Department have guidelines for what must be included in training, rather than have the training be "Department approved" in order to streamline the training development and implementation process both initially and for future training development?

Area: Service Planning and Delivery

Background:
Based on the proposed changes concerning the service planning and delivery, it was noted that the term "recommendations" is now used when getting input from other involved parties for treatment planning. We suggest that the term be replaced with "input" as is the current standard and practice. Recommendations are different from input and we believe this clarification will help avoid role confusion. Also noted is that the assessments are proposed to be updated at least every six months to address changes or lack of progress. We believe that the Individual Treatment Plan (ITP) being updated will be sufficient.

Recommendation(s):

- 5240.21 (8d) language needs to be changed from recommendations to input.
- 5240.21 If a child is not progressing within 90 days, can this be addressed in the ITP only rather than in the assessment?
- 5240.21 (a) Clarification on the meaning of initiation of IBHS.
- 5240.22 (8) Too restrictive-consider removing the language "each setting" to allow flexibility to meet individual therapeutic needs.
- 5240. (d) (3) Clarify the definition and intent of transition plan as part of safety/crisis plan.

Area: Discharge

Background: It has been our experience that at times families do not answer or returns call even after several attempts. This could present a barrier based on the way the proposed regulations are written in terms of "contact." We recommend that the language be changed to include "attempted" with the contacts to allow for the situations where families do not engage.

Recommendation(s):

- 5240.32 (4) language change to documented 2 telephone contact attempts, and would this be billable?
- 5240.31 (C) (2) Will a new written order be required?

Area: Records

Background:
It is unclear why this is listed in this section and we recommend 5240.41(b)(3) be deleted and replaced with language that permits the identification of a sample size for reviews which is a more realistic expectation. The way this is currently stated in this section, we estimate we would have to hire two additional full time employees to do reviews based on the 500 families and subsequent records we currently have. We agree that the review of records at least every 6 months is a positive addition, but this will only be manageable if we can have samples.

Recommendation(s):
5240.41 (b) (3) Suggest that this language/requirement be deleted here and moved to 5240.61 Quality Improvement requirements, as this would support the method for establishing sample size, frequency of review and staff qualifications to perform the review.

Area: Quality Improvement

Background:
There is a general consensus among providers who we have collaborated with in the evaluation and response to the proposed regulations, that there is concern about the requirement to make publically available some data as part of the quality improvement process. This concerns stems largely from the ambiguous nature of the proposed language around what would be expected, how it would be made available, and for what purpose it would serve. Data without context can be a concerning thing and make providers appear inaccurately in a positive or negative light. It should be clarified and considered carefully what aspects would be public. Access Services has a plan that is public and provided to stakeholders upon request including goals and progress, but the underlying data, which requires context, interpretation and evaluation is not for public consumption for the reasons stated above. In particular, the context of any provider data must at a minimum be provided by the provider for any data.

Though the requirement for provider agencies to have a quality improvement process and plan is a positive addition, it is overly prescriptive in the detail of the requirements. Many agencies, including Access Services, have already developed impactful plans specific to identified areas within the agency. By providing overly prescriptive requirements this diminishes the provider independence is determination of the greatest areas of need and focus based on a variety of factors which may vary from one provider to the next. Below we recommend replacing the current proposed language with more flexible language which still establishes requirements, but allows for individual provider focus as determined internally necessary and desired.

Recommendation(s):
5240.61 (2) (b) Clarification of what needs to be shared with the public related to the annual quality reports. In addition, any data to be made public must allow for providers to establish the context of data so it is not left up to interpretation to be potentially misconstrued positively or negatively.

Replace current proposed language in regulations with the following:
"The quality management plan shall include the following:

- Performance measures.
- Performance improvement targets and strategies.
- Methods to obtain feedback relating to personal experience from individuals, staff persons and other affected parties.
- Data sources used to measure performance.
- Identification of the actions to address annual findings.
- Roles and responsibilities of the staff persons related to the practice of quality management.
- The provider quality improvement plan shall be reviewed at least annually, and revised at least every 3 years."

Area: Individual Services

Background:
Currently there is no BHT certification for the PA Certification Board. What is the scope of certification in PA for BHT? What are costs, requirements, and ongoing supervision? Will the BHT also be ABA focused, or will this certification be more inclusive of approach? If this section is primarily MH -why would the BHT have to meet the same criteria as an ABA program staff?

(a)(1) and (c) (1) (2) should be the same language.

What counts as a mental health direct service practicum? For example: some BSC's with an education degree do student teaching, but not necessarily with mental health. Will this count? Needs clarification on mental health direct service practicum.

"(b) Behavior specialists who provide individual services to children diagnosed with ASD for the treatment of ASD shall meet the qualifications for a behavior specialist analyst in 5240.81(c) relating to qualifications"

BSC's who are licensed should be able to provide Individual Services to children who are diagnosed with ASD without meeting the qualifications under 5240.81 (c) because they are providing non-ABA services. This would then be a strength of the new regulations, allowing children diagnosed with ASD to have the option of non-ABA behavior services depending on their need, and thus increasing the individualization of services.

Recommendation(s):
5240.71
Under Behavior Specialist qualifications remove (b) to allow for a modality of treatment for clients diagnosed with ASD other than ABA. Make a qualification for services provided for ASD under Individual Services that ABA was considered and why it was not recommended.

Under BHT-(d) (3) remove full-time experience so that internship experience can count Remove mental health specific requirement due to the limited pool of candidates– child/youth/young adult experience in non-MH capacities would be sufficient.

Area: 5240.72 Supervision

Background:
Access Services currently has approximately 110 clinicians and 77 TSS across three locations. Currently the clinicians are receiving supervision one time a month with the proposed additional supervision and a third face to face supervision the cost for supervision will be a significant financial undertaking, with calculations showing the cost to the provider agency increasing close to 200%. Based on a fiscal impact analysis it appears that additional costs just to Access Services alone in this area could approach a $100,000 increase.

2.) Training Requirements

The additional training hours- 15 for TSS and 16 for clinicians- will have a financial impact on agencies. For the TSS, this could prove significant since the additional 15 hours are related to the onboarding of new staff. Will there be any provisions to help off-set this cost, beyond allowing them to carry it over from other agencies they have worked for? For our agency, we have about 110 BSC/MT's and hire about 20 TSS annually. The increase to costs would double for onboarding. For annual training for BSC/MT's this would result in an increase of 1760 hours which would be unfunded hours. This could potentially result in increased cost to the agency of up to $50,000.

Recommendation(s):

(2) and (3) cumbersome and not cost effective. (3) 30 minutes/every 3 months/each IBHS staff person is intrusive. Direct observation for this timeframe tells us very little about fidelity to practice. Are there other ways to monitor adherence to fidelity for example case reviews?

The proposed regulations state "each IBHS staff person" which applies to Master's level staff, and would create an increased amount of supervision which requires an infrastructure that will actually decrease access to treatment.

(3) This would not be therapeutically appropriate for a mobile therapist or Master's level clinician to have an on-site supervision during a session. There is a therapeutic process and having an on-site supervision during session could be intrusive and a barrier to therapy. Recommendation is that mobile therapist role not be included in the quarterly on-site supervision. If supervision of sessions is included in the regulations, we recommend that alternative methods of oversight be explored, such as video taping of a session, with family permission, and then utilized for review and supervision. This is currently the practice in other services such as Family Based Services.

- Consistency around who can provide supervision in both Individual Services and ABA.

- (h) In addition to the IBHS Supervisor, add the BS and MT's to the consult with staff during all service hours.

5240.73 Staff Training Requirements

Department approval of all training doesn't allow flexibility for providers to ensure training is cost-effective and timely. Recommendation is for guidelines in what trainings should cover and then review of trainings during licensing for quality improvement if required.

- 5240.75 (a) Behavior Specialist consultation should be expanded to include all necessary treatment team members.
- BSC should be able to do all activities provided by the BHT.
- Add supervision of BHT's requirements language for BSC's which is in the BSA section.
- (b)MT's should be able to consult with all necessary treatment team members. MT's should be able to do all activities provided by the BHT.
- BSC and MT's should be able to develop, design and direct an ITP. There is inconsistency around this activity/language.
- (c)(9) Referrals: Should not be BHT role; Recommendation is to include this responsibility under BSC and MT's role.

Area: Applied Behavioral Analysis

Background:

- This is unknown because there is no certification developed by the PA Certification Board.
- 5240.82
- What is the difference between service delivery of the ABSA and the BSA? The roles need clarified.
- Are both a BSA and an ABSA required on each case?
- 5240.87 ABA Services Provision
- How are ABSA services authorized? Are they prescribed at the discretion of the agency?

Recommendation(s):

- Can clarity of language be added to determine the roles of BSA and ABSA on a case, and if one or both are required on a case? Currently this is unclear.
- Throughout the regulations, certifications which are not currently in place are referenced. Rather than developing new certifications where current certifications already exist, a timeline should be built in for receiving the certifications already available; similar to what was done for getting the RBT or BCAT.

Area: Supervision 5240.82

Background:

- BSA'S will have two supervisions a month and one individual face-to-face a month from the ABA clinical director.
- A BSA will provide supervision to the ABSA one hour a week if the ABSA works at least 37.5 hours per week or twice a month if the ABSA works less than 37.5 hours a week along with the one individual face-to-face a month. Since supervising the ABSA is not a billable service, this would be a direct cost to providers. Agencies would be required to pay the BSAS a non-billable rate.
- During the 30 minutes of direct observation, will the BSA'S be able to bill for that 30 minute period on a quarterly basis?
- An ABSA will provide supervision to the BHT-ABA once a week if the BHT-ABA works 37.5 hours a week or twice a month if the BHT-ABA works less than 37.5 hours a week. Since supervision is listed under the duties of the BSA, would this then be a billable service? Currently, this supervision is not a billable service and if it continues to be so, this would cost providers to pay for the ABSA facilitating the supervisions.

Recommendation(s):

- Due to the intensive supervision requirements set forth, could the 30 minute period of direct onsite supervision be decreased from quarterly to twice a year?
- 5240.81 add a minimum qualification of bachelor's degree.
- Needs consistency with the defined timeframes for achieving the proper credential to provide service.
- Add the consultation language same as BSC; add observation and collection of data.
- The BSA should be able to carry out the same duties as the ABSA and the BHT-ABA.

Area: Group Services

Background:

- 5240.102 – Can someone other than the Clinical Director provide supervision to the MHP's.
- 5240.107 – Is there any place for ABA to be done as part of the group program? This is not listed under either the MHP or the MHW.
- Should consultation with client's team be something the MHP can do.
- 5240.108 – (3) is there clarification on what is meant by "assurances."
- (5-1) – clarification around continuity of services when school is not in session.

Recommendation(s):

- 5240.103 Staff Training Requirements: Who will fund the 16 hours of Department-approved training annually for non-licensed clinicians? This will be a large added cost for agencies.
- 5240.105 Assessment: Purpose change of days, instead of five days of initiation, extends to 15 days to standardize with the other services and added time for agencies to complete a quality assessment. *not sure we want to push on the 5 vs. 15 days for group assessment. It's a little different of a service and the timeline makes sense as a result. Is this something we could get a waiver for if our setting dictated more of an extended timeline? We should be consistent with addressing funding concerns as well – either put them in the areas they are related to or add them all at the end*

Funding Concerns:

As noted above, we have serious concerns about the proposed regulations and the impact they will have on service delivery, staffing, and program budgets. It has been stated that the changes proposed in the new IBHS regulations will be "cost neutral"; however, the unfunded mandates proposed will create additional administrative, supervision and staffing costs. Increases in operational costs for publicly-funded programs require action to appropriate more funding.

The following area specific areas identified to support these concerns surrounding funding and the cost associated with the promulgation of these regulations in current form.

Unfunded Mandates

Additional training requirements

- BHT from 39 to 54 hours in the first 6 months.
- RBT / BCAT initial certification costs and ongoing recertification.
- MT/BSC 16 hours/year (currently not required).
- Additional staff time to be paid for the higher supervision requirements.
- Individual training plans – being based on hire date rather than annual date determined by the agency. There must be time to do individual evaluation.
- Trainings having to be approved by the Department will require additional time and funding.
- Proposed certifications being created through the PA Certification Board for ABSA and BSA.

Supervision requirements

- Onsite quarterly supervision requirement for all IBHS staff in addition to regular supervision hours – this can be significant depending on the number of staff.
- Unable to bill for supervision under Individual BSC but it is listed as a duty under ABA. If it's listed as a duty under a particular role does this make it a billable service?
- Additional supervision requirements mean hiring additional staff. Since supervision is not funded, this is a significant added expense for providers.
- Travel expenses for onsite supervision (time and mileage).

Staff qualification requirements

- Administrative Director being required to be a Masters Level will mean this position is a higher cost one. As noted in our comments, we do not believe this position should require a Master's degree to successfully fill this role.
- Access Services would now have to hire multiple Clinical Directors due to the qualifications for different IBHS programs provided in the same agency, which would be a significant cost increase. Using clinical staff here removes them from the possibility of doing direct care.
- Based on the size of our programs currently, we estimate that we would have to hire several Administrative Directors and Clinical Directors. Based on the current proposed qualifications of these positions, this may increase non-billable costs approaching $200,000 for the agency.
- Number of supervisors required for the level of supervision may add a cost while also removing clinical staff from the direct provision of services.
- BCBA's are paid significantly more in other industries than what will be IBHS. This will exacerbate an already difficult recruiting environment and may make wait times for services higher. To retain this level of staff could be a significant financial cost for providers.

Quality Requirements

All of these proposed requirements are time intensive with no funding attached. This will require hiring additional administrative staff in order to be in compliance.

- Annual reporting – both the internal and what needs to be given to the public.
- Level of auditing – frequency of record reviews.
- Community resource list to be maintained and updated annually.
- Clinical Director signing off on all ITP's – this will also require review time.
- Discharge follow up calls – if this is after services it is not billable?
- Annual licensing requirements.
- Having to update organizational chart sent within 10 days rather than presented at the next licensing visit.

Other areas

- Initial program description.

- Having to do individual site licensing and all this entails annually.
- Having to have program descriptions for each location, even if the same service is going to be provided in all locations and agency has, and the amount of time this duplication will require.

Conclusion

Access Services, along with our dedicated staff and contractors of over 600, as well as the close to 5000 individuals we support across programs, appreciates your consideration of our comments to these proposed changes. Thank you.

Sincerely,

Whitney Smith, Vice President of Children and Family Services, and Audra Nihart, MA LBS, Director of BHRS on behalf of Access Services Executive Management Team

CC: Honorable Gene DiGirolamo, Chairman, House Human Services Committee