Statutory Authority

The Department of Human Services (Department), by this order, adopts the regulations set forth in Annex A under the authority of §§ 201(2) and 1021 of the Human Services Code (62 P.S. §§ 201(2) and 1021) and § 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)). Notice of the proposed rulemaking was published at 48 Pa. B. 4762 (August 4, 2018).

Purpose of Regulation

The purpose of this final-form rulemaking is to codify the minimum licensing standards and program requirements for participation in the Medical Assistance (MA) Program and MA payment conditions for agencies that deliver intensive behavioral health services (IBHS) to children, youth and young adults under 21 years of age with mental, emotional and behavioral health needs. IBHS includes individual services, applied behavior analysis (ABA) services, group services and evidence-based therapy (EBT) delivered through individual services, ABA services or group services.

The rulemaking supports children, youth and young adults with mental, emotional and behavioral health needs because they can continue to receive a wide array of services that meet their needs in their homes, schools and communities, including EBT delivered through individual services, ABA services and group services.

This final-form rulemaking will replace the requirements for behavioral health rehabilitation services (BHRS) previously set forth in bulletins issued by the Department. It also adds a requirement for a separate and distinct license for agencies that deliver these services and additional oversight of services. The rulemaking eliminates redundancies in bulletins, streamlines the admission process for IBHS, establishes

training requirements and qualifications for staff delivering IBHS and includes provisions to protect the health and safety of a child, youth or young adult receiving services.

Background

BHRS were developed in response to the Omnibus Budget Reconciliation Act of 1989 (Pub. L. No. 101-239), which amended section 1905(r)(5) of the Social Security Act (42 U.S.C.A. § 1396d(r)) to require states to provide "necessary health care, diagnostic services, and other measures described in [the Social Security Act] . . . whether or not such services are covered under the State plan." BHRS are individualized services provided in the home, school, or community to meet the needs of children, youth and young adults with mental, emotional and behavioral health needs. The Department has issued bulletins to inform providers of the policies and procedures governing BHRS, many of which were issued when these services were new in the continuum of care. Since the publication of the bulletins, the service delivery system has become more complex and sophisticated. Individuals who receive BHRS and family members of individuals who receive BHRS, advocates, providers and county administrators have also expressed the need for revised standards for the delivery of BHRS. In response, the Department engaged a diverse group of stakeholders to provide input into the development of regulations that would address the delivery of IBHS.

Affected Individuals and Organizations

The final-form rulemaking affects children, youth and young adults with mental, emotional or behavioral health needs currently receiving BHRS, their families and caregivers and the agencies that provide these services. Approximately 380 agencies are enrolled in the MA Program and currently provide BHRS to approximately 180,000

children, youth and young adults. The final-form rulemaking also affects providers that serve children, youth, and young adults with a behavioral health diagnosis, including autism spectrum disorder (ASD), that are not currently enrolled in the MA Program.

The Department engaged in an active community participation process throughout the development of this final-form rulemaking to ensure that children, youth and young adults who need IBHS and their families and the agencies that provide the services had the opportunity to provide input, express concerns and participate in the drafting process.

A total of 75 individuals were involved in a stakeholder workgroup that provided input on the proposed rulemaking, including providers of BHRS, advocates for individuals with ASD, physicians, family members of children receiving BHRS including ABA services, county administrators, representatives from provider associations, the Office of Mental Health and Substance Abuse Services (OMHSAS) Mental Health Planning Council, the Pennsylvania Mental Health Consumers Association, the Pennsylvania Health Law Project, Disability Rights Pennsylvania and MA behavioral health managed care organizations (BH-MCOs). From May to September 2016, the Department participated in face-to-face meetings, telephone conference calls and webinars with stakeholders. The purpose of the workgroup meetings was for the Department to gather input and listen to concerns from interested parties regarding the development of a regulation for the licensure of agencies that will be providing IBHS.

Each of the major sections of the final-form rulemaking were reviewed and discussed by members of the workgroup through a series of six telephone conference calls and webinars and two face-to-face meetings. One of the initial recommendations from the

stakeholder workgroup was to change the name of the service from BHRS to IBHS. Key sections of the proposed rulemaking were the focus of the discussion during each of the telephone calls. Topics discussed with the stakeholder workgroup included the array of services to be included in the rulemaking, staff qualifications and training requirements for each service, service planning, coordination of care and requirements for provider eligibility. Workgroup members were provided with notes and drafts of the rulemaking after each call or webinar. A dedicated e-mail account was established for workgroup members to submit written comments between meetings. Workgroup members were requested to gather input and feedback from other interested parties during the drafting of the proposed rulemaking. In addition, information on the proposed rulemaking was provided at meetings with organizations and committees, including the Rehabilitation Community Providers Association, including its Mental Health Committee and Children's Committee; committees sponsored by the County Commissioner's Association of Pennsylvania, including the County Administrator's Advisory Committee, the Mental Health Committee and the HealthChoices Committee; county Mental Health Administrators and Child and Adolescent Service System Program Coordinators; the Managed Care Subcommittee of the Medical Assistance Advisory Committee; and the Mental Health Planning Council. Numerous edits were made to the proposed rulemaking based upon the comments received from the workgroup members and other interested parties.

The stakeholder workgroup met in January through March 2017 to provide input on Chapter 1155, the companion rulemaking, which addresses payment for IBHS. There were again face-to-face meetings, telephone conference calls and webinars with

stakeholders and workgroup members who provided comments and feedback on Chapter 1155, the payment rulemaking, and additional comments and feedback on Chapter 5240, the licensing rulemaking. The proposed rulemaking was revised after each meeting to reflect the input of workgroup members. Workgroup members were able to provide written comments between meetings using the e-mail account.

After publication of the proposed rulemaking, the Department reconvened the stakeholder workgroup. The stakeholder workgroup met in December 2018 and January 2019 to review and discuss some of the comments the Department received on the proposed rulemaking, including comments from the Independent Regulatory Review Commission (IRRC) and two legislators. The stakeholder workgroup discussed feedback the Department received about the decision to no longer require an evaluation to initiate services and instead require an assessment in the child's, youth's or young adult's home and community and the decision to no longer require Interagency Service Planning Team (ISPT) meetings prior to the initiation of services. The stakeholder workgroup also discussed whether the final-form rulemaking should include the requirement for post-discharge phone calls, suggestions for changes to the names of services and revisions to staff qualifications, the expected difficulty in implementing the reinitiation of service provisions included in the proposed rulemaking, possible changes to the supervision requirements, the challenges with creating a new certification through the Pennsylvania certification board prior to promulgation of the final-form rulemaking, concerns about capacity as a result of new staffing qualifications, the use of restrictive procedures, the need for 2:1 staffing or safety plans, and rates for services.

The Department appreciates the workgroup members' expertise, time and commitment to the rulemaking and the helpful comments which guided the drafting of the rulemaking.

Accomplishments and Benefits

This final-form rulemaking benefits children, youth and young adults with mental, emotional and behavioral health needs by establishing a minimum standard for licensure of IBHS agencies, minimum requirements for IBHS agencies to enroll in the MA Program and conditions for the MA Program to pay for IBHS. In addition, the supervision and training requirements included in the final-form rulemaking will contribute to the development of a qualified IBHS workforce to deliver treatment services, which will help to improve clinical outcomes for children, youth and young adults receiving IBHS.

The final-form rulemaking will also facilitate the accessibility of behavioral health care for children, youth and young adults by eliminating requirements that have been identified as barriers to accessing services by workgroup members, such as convening an ISPT meeting prior to the delivery of services and requiring a comprehensive evaluation prior to a referral for services. In addition, a child's, youth's or young adult's treatment needs will be assessed in the home and community setting as part of the initiation of treatment and staff who assess a child, youth or young adult will be able to provide services to the child, youth or young adult, which allows for continuity of care, a smoother transition to service provision, reduction in inconsistencies in treatment approach and less delay in beginning treatment.

Furthermore, this final-form rulemaking promotes the use of EBTs by supporting their delivery through individual services, ABA services or group services, which may reduce the need for higher levels of care or out-of-home placements for children, youth and young adults.

Fiscal Impact

The overall fiscal impact for each IBHS agency will vary and depends upon the services provided by the agency, the current organizational structure of the agency, and the IBHS agency's current qualification, supervision and training requirements. Because of the wide array of existing staffing patterns, supervision and training requirements for staff who currently provide BHRS, the Department cannot determine the exact fiscal impact of the final-form rulemaking. For example, although training and supervision is not currently required for individuals with graduate degrees who provide services, most agencies provide some training and supervision for those individuals. Likewise, it is unknown to what extent IBHS agencies will need to hire new staff or encourage existing staff to obtain additional qualifications. For example, some IBHS agencies that provide ABA services may already employ a clinical director that meets the qualification requirements in the final-form rulemaking.

In addition, while the rulemaking imposes new training requirements on IBHS agencies, the Department has included provisions in the rulemaking that are intended to reduce the fiscal impact on IBHS agencies for training. The rulemaking clarifies that staff do not need to repeat initial or annual training when employed by a new IBHS agency. It also promotes the employment of licensed or certified individuals, which will reduce training costs because training acquired through college coursework or as part

of obtaining a license or certification is permitted to be counted towards the required staff training. Allowing IBHS agencies to count training acquired through coursework or as part of obtaining a license or certification will reduce the number of trainings agencies need to provide and will result in agencies having to spend less time creating their own trainings. It will also shorten the time between when a staff person is hired and when the staff person can begin to provide services because the staff person will require less training prior to beginning to provide services. In addition, when training is acquired through college coursework or as part of obtaining a license or certification, concerns about what was included in the training are alleviated and agencies will have more confidence that a staff person has the required training.

Likewise, it is unknown to what extent the requirement that an IBHS agency have a quality improvement plan will be an additional expense for IBHS agencies. Agencies that are currently accredited by entities such as The Joint Commission or the Council on Accreditation (COA) complete quality improvement plans, as do many providers licensed by OMHSAS. Given the common practice of utilizing quality improvement activities, costs to implement this requirement may be minimal.

IBHS agencies will also have the ability to provide assistant behavior consultation-ABA services, which will be supervised by a qualified individual. This new service will allow IBHS agencies to increase the number of staff available to provide ABA services and provide more services without impacting the health and safety of children, youth and young adults receiving services.

To the extent that IBHS agencies incur additional costs as a result of this rulemaking, these additional costs will be taken into consideration when the Department determines

future BH-MCO capitation rates. The Department also anticipates that the need for additional licensing staff to license IBHS agencies will result in an additional cost to the Department.

Any additional costs to the Department may be offset by some savings to the Department as a result of the rulemaking. The rulemaking includes qualifications for staff who provide ABA services that are consistent with those required by private insurers, which is expected to result in increased third party payment for services for children, youth or young adults who also have private insurance. Similarly, the admission process for ABA services will be more in line with the admission process used by private insurers, which may result in private insurers paying for the services that result in a written order for ABA services, completing an assessment or completing an individual treatment plan (ITP).

The rulemaking also establishes minimum standards for agencies that provide IBHS that include minimum staffing, training and supervision standards. This may increase the knowledge and skills of staff providing IBHS and may result in improved outcomes for children, youth and young adults who receive IBHS. Improved outcomes may decrease costs for the Department because they may result in a decrease in the utilization of higher levels of more costly care such as residential placement or out of home placement, a decrease in the length of time a child, youth or young adult receives IBHS or a decrease in the amount of services a child, youth or young adult needs.

No cost to local government or individuals receiving IBHS are anticipated by the final-form rulemaking.

Paperwork Requirements

The final-form rulemaking may result in increased paperwork for some agencies because it requires IBHS agencies to develop additional policies and procedures and includes a new requirement that IBHS agencies develop quality improvement plans, emergency plans, staff training plans and written agreements to coordinate care with other agencies. Agencies that are currently accredited by entities such as The Joint Commission or COA already are required to have a quality improvement plan and an emergency management plan. In addition, most agencies currently have written policies and procedures that address some of the topics required by the final-form rulemaking and agreements to coordinate care with other agencies. The elimination of the requirement for an ISPT meeting will decrease the paperwork required to document the meeting and result in less information needing to be submitted if prior authorization of IBHS is required.

Public Comment

Written comments, suggestions and objections regarding the proposed rulemaking were requested within a 30-day period following its publication in the *Pennsylvania Bulletin*. The Department received 107 written responses containing approximately 1400 comments. These comments represented feedback from a broad spectrum of advocates, parents, providers, professionals, legislators, county entities and BH-MCOs. Public comments were received from all five BH-MCOs that provide behavioral health services to children, youth and young adults in the Commonwealth; statewide advocacy groups, such as Disability Rights Pennsylvania and Pennsylvania Health Law Project; provider groups, such as the Pennsylvania Council for Children, Youth, and Family Services and the Rehabilitation and Community Providers Association; and professional

associations, such as the Pennsylvania Psychological Association. Feedback was also received from a variety of providers, including large statewide providers, new providers of ABA services, rural providers, small agencies and agencies owned by licensed psychologists. The Department also received comments from IRRC.

Discussion of Comments and Major Changes

Following is a summary of the major comments received within the public comment period following publication of the proposed rulemaking and the Department's responses to those comments. A summary of additional changes to the proposed rulemaking is also included.

Replacement of BHRS bulletins

IRRC stated in response to the Department's explanation that the rulemaking is replacing information previously conveyed by the Department through bulletins that it is unclear from the description of the rulemaking provided in the preamble of the proposed rulemaking if any of the language from the bulletins was carried over to the rulemaking. IRRC requested that the Department provide a rationale for each section in the rulemaking and explain if that language previously existed in bulletins issued by the Department.

Response:

The service array that is addressed in the bulletins has been carried over in the rulemaking. BHRS includes therapeutic staff support (TSS) services, mobile therapy services, behavior specialist consultant (BSC) services, behavior specialist consultant-autism spectrum disorder (BSC-ASD) services, summer therapeutic activities programs (STAP) and services that are not included on the MA Program fee schedule but are

approved through the program exception process. Individuals who provide behavioral health technician (BHT) services and behavioral health technician-applied behavior analysis (BHT-ABA) services have similar qualifications and responsibilities as individuals who provide TSS services. Mobile therapy services can continue to be provided by individuals with qualifications similar to the qualifications for mobile therapists included in the bulletins. In addition, although the Department has changed the name of BSC services and BSC-ASD services to behavior consultation services and behavior consultation-ABA services, the services provided through these services are the same as the services that were provided through BSC services and BSC-ASD services. The Department has also included in the final-form rulemaking with some modifications the qualifications for providing BSC services and BSC-ASD services. Furthermore, the Department will continue to allow STAP to be provided through group services. In addition to the staff who can provide BHRS, the bulletins also address which providers can enroll and receive payment for providing BHRS. These are the providers that the Department expects will obtain an IBHS agency license.

The bulletins also impose for individuals who provide TSS services initial and ongoing training requirements, onsite supervision requirements, which the Department calls "assessment and assistance," and individual and group supervision requirements. The rulemaking imposes similar training and supervision requirements for individuals providing BHT services. In addition, the bulletins require providers to coordinate services, draft treatment plans and plans for discharge, which are also all required by this rulemaking. The requirement that providers of BHRS submit service descriptions for review and approval by the Department is also addressed in the bulletins. The

Department is continuing to require that service descriptions be submitted, although they will now be reviewed as part of the licensing process and the Department has updated some of the information that must be included in a service description as a result of its experience reviewing service descriptions. The bulletins also address the requirements for authorization of TSS services, which include a face-to-face evaluation, an ISPT meeting and a detailed treatment plan. As a result of input from stakeholders, the Department will no longer be requiring ISPT meetings. In addition, instead of requiring a face-to-face evaluation, the Department will be requiring a face-to-face interaction, which may include an evaluation, that results in a written order for IBHS and an assessment followed by the completion of an ITP for IBHS to be initiated. Finally, the bulletins encourage the use of a functional behavior assessment. The Department has changed this requirement from encouraging an assessment to requiring an assessment because assessments provide specifics for treatment delivery, including the number of hours of each service needed at each location.

Promulgating this rulemaking will allow the Department to consolidate and update information provided in multiple bulletins issued over a 24-year period. The Department has found that because not all of the information was included in one place, there were redundancies in the bulletins and it was not always clear which provisions applied. In addition, many of the bulletins were issued when these services were new in the continuum of care and as a result of the service delivery system becoming more complex and sophisticated, information needs to be updated.

The Department has drafted a payment regulation so that providers understand what is required to receive payment from the MA Program. A regulation that governs the

licensing of IBHS agencies is needed to establish consistent standards and ensure that these standards are met. In addition, the Department has addressed staff qualifications, training, supervision and service planning and delivery in the rulemaking because it is seeking to align the services that are on the MA Program fee schedule with the services that are not on the MA Program fee schedule.

This rulemaking is also needed to address issues that are not currently addressed in the bulletins, such as the organizational structure of an IBHS agency, staff training plans, agency records, quality improvement plans and additional supervision and training requirements. New requirements, such as staff training plans, were added because staff training plans ensure that staff are properly trained, which is expected to have a positive effect on the outcomes of services. Requirements relating to agency records are included to establish the specific items that must be kept by an IBHS agency, which will be used to license providers, and to clearly identify the information that must be kept in IBHS records for an individual, which will be used to provide services. The requirement that records must be reviewed is included in this rulemaking to ensure that information is accurately maintained in a child's, youth's or young adult's record. The Department has also included a quality improvement section in the final-form rulemaking because it believes that IBHS agencies should review the quality, timeliness and appropriateness of services they provide to children, youth and young adults and make improvements where needed. Finally, the Department has included training and supervision requirements for graduate-level professionals in the final-form rulemaking to ensure that individuals providing these services receive annual training and ongoing supervision.

One commentator asked if the Department will render the existing BHRS bulletins obsolete after the rulemaking is promulgated.

Response:

The Department will obsolete the BHRS bulletins once this rulemaking is promulgated.

IRRC also requested that the Department identify the language in the ABA sections of the rulemaking that satisfies the requirements of the settlement agreement reached in *Sonny O v. Dallas*, No. 1:14-CV-1110 (M.D. Pa.).

Response:

The settlement agreement requires the Department to specify minimum qualifications, including training and experience, as well as supervision requirements for practitioners who provide ABA services to children with ASD. The minimum qualifications must be sufficient to enable practitioners who provide ABA services to have the knowledge and skills about ABA set forth in Exhibit A to the settlement agreement.

The Department has addressed the minimum qualifications and experience requirements to provide ABA services in § 5240.81 (relating to staff qualifications for ABA services), the training requirements to provide ABA services in § 5240.83 (relating to training requirements for staff who provide ABA services) and the supervision requirements for individuals who provide ABA services in § 5240.82 (relating to supervision of staff who provide ABA services). The Department, with input from stakeholders, has determined that the qualification requirements, in addition to the supervision and training requirements, are sufficient to enable the practitioners who

provide ABA services to have the knowledge and skills about ABA set forth in Exhibit A to the settlement agreement.

Services provided through IBHS

IRRC and 22 commentators expressed that they were confused about what services could be provided through IBHS and the qualifications of the individuals who could provide each service.

Response:

In response to these concerns, the Department has simplified the overall structure of the rulemaking in a number of ways. The Department has revised the rulemaking to better explain the services that can be provided through IBHS and the qualifications required to provide a service. The Department has also changed the name of some services.

Individuals with graduate-level qualifications can provide behavior consultation services, mobile therapy services, behavior consultation-ABA services and behavior analytic services. Behavior consultation services consist of clinical direction of individual services, development and revision of the ITP, oversight of the implementation of the ITP and consultation with a child's, youth's or young adult's treatment team regarding the ITP. Mobile therapy services consist of individual therapy, family therapy, development and revision of the ITP, assistance with crisis stabilization and assistance with addressing problems the child, youth or young adult has encountered. Behavior analytic services and behavior consultation-ABA services consist of clinical direction of ABA services, development and revision of the ITP, oversight of the implementation of the ITP and consultation with a child's, youth's or

young adult's treatment team on the ITP. In addition, behavior analytic services include functional analysis. Individuals with graduate-level qualifications can also provide group services, which include group and family psychotherapy, design of psychoeducational group activities, clinical direction of group services, creation and revision of the ITP, oversight of the implementation of the ITP and consultation with the child's, youth's or young adult's treatment team on the ITP.

Individuals with or without graduate-level qualifications can provide assistant behavior consultation-ABA services. Assistant behavior consultation-ABA services consist of assisting an individual who provides behavior analytic services or behavior consultation-ABA services and providing face-to-face behavioral interventions.

Individuals without graduate-level qualifications but who meet certification, training or experience requirements can provide BHT services or BHT-ABA services. BHT services and BHT-ABA services consist of implementing a child's, youth's or young adult's ITP. If group services are being provided, BHT services and BHT-ABA services consist of assisting with conducting group psychotherapy and facilitating psychoeducational group activities, in addition to implementing the child's, youth's or young adult's ITP.

In addition, originally the Department intended that EBT would be provided as a separate service. As part of simplifying the structure of services, the Department has revised the final-form rulemaking to allow for the provision of EBT through individual services, ABA services or group services.

Access to services

IRRC and 21 commentators were concerned that the qualifications for IBHS agency staff will create access issues and cause delays in children, youth and young adults receiving services because agencies will not be able to find and retain staff who meet the qualifications in the rulemaking. One of the commentators noted this concern specifically with regards to ABA services, and another commentator shared concerns about access to services in rural areas.

Response:

The Department does not agree that the qualifications included in the final-form rulemaking will cause access issues or delays in children, youth and young adults receiving services. The Department has included a variety of acceptable qualifications for each service. In addition, the Department has considered stakeholder input about both access to services and appropriate qualifications for individuals providing services and has added new qualifications for individuals who provide BHT services or BHT-ABA services, the two most highly utilized services. The Department has revised the final-form rulemaking to include that an individual with a high school diploma or the equivalent to a high school diploma who has completed 40 hours of training covering the RBT Task List can provide BHT services or BHT-ABA services and individuals who have 2 years of experience and 40 hours of training can provide BHT services or BHT-ABA services. In addition, the Department is allowing individuals who provide BHT services or BHT-ABA services additional time to obtain the qualifications needed to provide these services.

Rates and costs

One commentator suggested that the Department consider authorizing payment for time spent performing activities and duties, such as treatment plan writing, data analysis, training, coordination of services, establishing and maintaining written agreements, discharge planning, supervision, consultation and participation in treatment team meetings

Response:

The rulemaking does not change what activities are reimbursable.

IRRC and 28 commentators expressed concern that the Department has not addressed the increased costs to IBHS agencies as a result of the rulemaking.

Response:

To the extent that IBHS agencies incur additional costs as a result of this rulemaking, these additional costs will be taken into consideration when the Department determines future BH-MCO capitation rates.

IRRC asked the Department to address the economic impact on the regulated community of increased training requirements in the final-form rulemaking.

Response:

The Department developed training requirements using feedback from stakeholders. Most stakeholders supported the increased training requirements to enhance the skills of individuals providing services. The Department does not know what the specific economic impact of the costs of the training requirements will be for each provider because it depends on the IBHS agency's current training requirements. The Department has included in the rulemaking several provisions that are intended to reduce the costs to IBHS agencies as a result of the training requirements, including

that staff do not need to repeat initial or annual training when changing employment to a different IBHS agency. The rulemaking also promotes the employment of licensed or certified individuals, which will reduce training costs because training acquired through college coursework or as part of obtaining a license or certification is permitted to be counted towards the required staff training. Allowing IBHS agencies to count training acquired through coursework or as part of obtaining a license or certification will reduce the number of trainings agencies need to provide, will result in agencies having to spend less time creating their own trainings and will decrease the time between when a staff person is hired and when the staff person begins to provide services since the new staff person will require less training prior to beginning to provide services. In addition, when training is acquired through college coursework or as part of obtaining a license or certification, concerns about what was included in the training are alleviated and agencies will have more confidence that a staff person has the required training.

One commentator asked if there will be an increased cost to the HealthChoices primary contractors and oversight entities as it relates to monitoring and oversight duties.

Response:

There should be no increase in costs for the HealthChoices primary contractors and oversight entities as a result of the final-form rulemaking because they are already contracting with and monitoring providers of BHRS who are likely to become IBHS agencies.

Implementation of the rulemaking

Six commentators recommended that the Department make available provider friendly documents, including billing guidance, and provide technical support.

Response:

The Department intends to hold in-person and online trainings about the requirements in this rulemaking and make training documents available to providers, including by distributing documents through listservs and posting documents on its website.

Definitions

§§ 1155.2 and 5240.2 Definitions

Two commentators suggested that a definition of "written order" be added to the final-form rulemaking.

Response

It is not necessary to include a definition of "written order" in the final-form rulemaking. Section 1155.32(a)(1)(iv) (relating to payment conditions for individual services) and § 1155.33(a)(1)(iv) (relating to payment conditions for ABA services) address what must be included in a written order.

One commentator suggested adding a definition of the term "provider" to the rulemaking.

Response:

It is not necessary for the rulemaking to include a definition of "provider" because the Department uses the term "IBHS agency" to refer to providers in the rulemaking.

§§ 1155.2 and 5240.2 Definitions – ABA- Applied Behavior Analysis, consequence, variables and stimulus

The Department has revised the definition of "ABA-Applied behavior analysis" to be consistent with Act 62 of 2008 (40 P.S. § 764h). The definition of ABA included in Act 62 does not provide that ABA includes the attempt to address one or more behavior challenges or skill deficits using evidence-based principles and practices of learning and behavior and the analysis of the relationship between a stimulus, consequence or other variable, and therefore the Department has deleted these provisions from the definition of ABA included in the final-form rulemaking.

One commentator recommended that "applied behavioral analysis" be changed to "applied behavior analysis" because it is the term used in the behavior analysis field, including by the Behavior Analyst Certification Board and the Association for Behavior Analysis International. Other stakeholders also indicated that they agreed that this change should be made.

Response:

The Department agrees that "applied behavioral analysis" should be changed to "applied behavior analysis" and has made this change in the final-form rulemaking.

Two commentators noted that the definition of ABA used in the rulemaking appears to limit ABA services to children, youth and young adults with ASD and also appears to indicate that it is the only recognized treatment service for children, youth and young adults diagnosed with ASD. The commentators stated that ABA services can be used to treat children, youth or young adults without ASD.

Response:

Children, youth and young adults with ASD are eligible to receive all of the services identified in this rulemaking and ABA services are not limited to children, youth and

young adults diagnosed with ASD. The definition of ABA included in the rulemaking does not state that ABA services can only be provided to children, youth or young adults with ASD.

IRRC and one commentator suggested adding a definition for "skills deficits" that is consistent with the Department's Bulletin OMHSAS 17-02, Applied Behavioral Analysis Using Behavioral Specialist Consultant-Autism Spectrum Disorder and Therapeutic Staff Support Services, to clarify that acquisition of communication skills and age appropriate skills that are needed for daily living (e.g. toileting, dressing, etc.) are appropriate goals of ABA services.

Response:

The definition of ABA is consistent with Act 62 of 2008 (40 P.S. § 764h) and language used in OMHSAS Bulletin 17-02. Because the definition of ABA includes that ABA services can be used "to produce socially significant improvement in human behavior or to prevent loss of attained skill or function," it is not necessary to add a separate definition of "skill deficit." ABA can be used to assist a child, youth or young adult with acquiring communication skills or age appropriate skills that are needed for daily living.

One commentator recommended that the definition of "ABA" be revised to be consistent with the definitions used by either the Behavior Analyst Certification Board or Association for Behavior Analysis International because standards have been set nationally and Pennsylvania should not be behind the national standards set forth by the profession, which reflect current research and best practices.

Response:

The Department does not agree that the definition of "ABA" needs to be revised for Pennsylvania to not be behind the national standards set by the profession. The national standards are consistent with the definition of "ABA" used in the final-form rulemaking.

One commentator suggested changing the definition of "consequence" because it is confusing. The commentator suggested it be changed to "a directly measurable change of a child's, youth's or young adult's behavior resulting from a change in stimulus or stimuli." Another commentator stated that the definition of "variables" is confusing. In addition, IRRC and one commentator requested that the Department explain why the definition of "stimulus" only permits a behavior specialist analyst to manipulate events, circumstances or conditions.

Response:

As a result of the revisions made to the definition of ABA, the Department deleted the terms "consequence," "variable" and "stimulus" from the definition of "ABA." Because these terms were only used in the definition of ABA, it is no longer necessary for the Department to define them in the rulemaking.

§§ 1155.2 and 5240.2 Definitions – Caregiver

Two commentators stated that the definition of "caregiver" should be revised because a legal guardian should sign documents on behalf of a minor.

Response:

The Department agrees that a legal guardian or parent is able to sign documents on behalf of a minor. Because the Department has revised the final-form rulemaking to

clarify who can sign documents on behalf of a minor, the Department will not be revising the definition of "caregiver."

§§ 1155.2 and 5240.2 Definitions – EBT-Evidence-based therapy

IRRC and four commentators suggested replacing "Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices" with "Evidence-Based Practice Resource Center" in the definition of EBT because its name has changed.

Response:

The definition of EBT has been updated to include "Evidence-Based Practice Resource Center."

One commentator stated that it is unclear how a model intervention designated by the Department can be an EBT because the other requirements for a therapy to be considered an EBT have clear research-based support for their qualifications. The commentator believes that allowing therapies to be designated by the Department as EBTs could undermine the validity of calling a treatment an EBT and recommends that "designated as a model intervention by the Department" be removed from the definition of EBT. In addition, IRRC and one commentator asked what criteria will be used to determine whether an intervention developed by an IBHS agency can be a model intervention. Another commentator requested clarification as to how the Department will determine if an intervention is a model intervention, what process the Department will use to determine if an intervention is a model intervention, and how providers can submit programs or therapies to be considered as model interventions. One

commentator asked if the Department will maintain a searchable list of the EBTs it has designated as model EBTs.

Response:

The Department will publish on its website a list of EBTs it has approved to be delivered through IBHS. It will not be reviewing models not recognized at the national level and designating them as EBTs. The Department has removed "designated as a model intervention by the Department" from the definition of EBT.

One commentator recommended revising the definition of EBT to include the National Autism Center Standards Project and American Psychological Association Div. 25 and 12 standards, stating that standards have been set nationally and adopting national standards reflects current research and best practices.

Response:

The Department did not make the suggested addition to the definition of EBT because the recommended standards did not include models or programs for interventions, but instead included information on best practice treatment approaches.

§§ 1155.2 and 5240.2 Definitions - Group services

One commentator stated that the definition of "group services" does not include size limits on group activities, including staff to individuals being served ratios.

Response:

The Department has not imposed a specific size limit on group activities. An IBHS agency must include staffing ratios for each service it offers in its service description that it must submit to the Department for review and approval pursuant to § 5240.5 (relating to service description).

IRRC and one commentator requested that the last sentence of the definition of "group services" be moved to the body of the rulemaking because the requirement that group services can include individual interventions when included in the ITP is a substantive requirement.

Response:

The Department has removed the last sentence of the definition of "group services" from the rulemaking. The Department determined that this sentence was not necessary because the definition states that services are "primarily" provided in a group format. In addition, § 5240.96(d)(3) (relating to individual treatment plan) already includes that an ITP for a child, youth or young adult who is receiving group services must include any individual interventions needed to address the therapeutic needs of the child, youth or young adult to function in the home, school or community and § 5240.97(a) (relating to group services provision) provides that a graduate-level professional may provide individual psychotherapy. The Department also revised §1155.34 (relating to payment conditions for group services) to provide for payment for individual interventions provided as part of group services.

§§ 1155.2 and 5240.2 Definitions - IBHS—Intensive behavioral health services

One commentator is concerned that use of the term "intensive" will be misunderstood to mean that the rulemaking requires that individualized services are approved only if they are concentrated heavily within a specific time or continue for a very long period of time. The commentator further explained that this may not always be appropriate because some children, youth or young adults may benefit from short-term

psychotherapy and the rulemaking should permit short-term psychotherapy when appropriate.

Response:

The term "intensive behavioral health services" was discussed with stakeholders as a replacement for "behavioral health rehabilitation services" because behavioral health rehabilitation services did not accurately capture the array of services addressed in this rulemaking. The level of intensity of services and hours prescribed will continue to be based on medical necessity and will vary depending on a child's, youth's or young adult's needs. The final-form rulemaking does not preclude children, youth and young adults from receiving other medically necessary services.

§§ 1155.2 and 5240.2 Definitions – Individual services

The Department has deleted from the definition of "individual services" the term "one-to-one" to clarify that if medically necessary individual services can be provided by more than one individual at a time.

§§ 1155.2 and 5240.2 Definitions – Initiation of service

IRRC requested that the Department add a definition of "initiation" to the final-form rulemaking and use this term consistently throughout the rulemaking.

Response:

The Department has added a definition of "initiation of service" to the rulemaking. "Initiation of service" is defined as "[t] he first day an individual service, ABA service or group service is provided. This includes the first day an assessment is conducted."

§§ 1155.2 and 5240.2 Definitions – Staff

IRRC questioned if the training and supervision requirements in the rulemaking apply to independent contractors and consultants.

Response:

The Department has added a definition of "staff" to the final-form rulemaking to clarify that the qualification, supervision and training requirements apply to all staff, including independent contractors and consultants who provide IBHS.

§ 5240.2 Definitions

Multiple commentators and IRRC suggested that the Department add definitions of "behavior specialist analyst," "behavior specialist," "mobile therapist," "BHT" and "BHT-ABA" to the rulemaking to clarify the different qualifications and functions of each position. In addition, because the qualifications for licensure for behavior specialists are found in 49 Pa. Code § 18.524 (relating to criteria for licensure as behavior specialist), IRRC requested that the Department add a reference to this section.

Response:

The final-form rulemaking was revised to reflect what services may be delivered through each service rather than be written in terms of which individuals can provide each service, and as a result, it is not necessary to include definitions of these terms. The Department also did not include a cross reference to 49 Pa. Code § 18.524 (relating to criteria for licensure as behavior specialist) because it did not define the term "behavior specialist" and the final-form rulemaking does not include cross references to the qualifications for other licenses whose holders can deliver IBHS.

IRRC and five commentators suggested adding a definition of "mental health professional" because this position was defined differently than the other positions.

Response:

The Department has decided to no longer use the term "mental health professional" because it caused confusion since it is a term used in other Department programs. The Department is instead using the term "graduate-level professional." The Department has included in § 5420.91 (relating to staff requirements and qualifications for group services) the qualifications a graduate-level professional must meet.

One commentator suggested adding a definition for "crisis event" because it is a term that is used often in the rulemaking and it is unclear how the Department defines a crisis event.

Response:

The Department will not be adding a definition of "crisis event" to the final-form rulemaking because what is a crisis event varies from individual to individual. Each child, youth or young adult receiving services is required to have a crisis plan which will define what is a crisis event for that child, youth or young adult.

One commentator suggested that the Department add a definition of "qualified individual" so that it is clear who can supervise individuals who provide ABA services.

Response:

Because § 5240.82 (relating to supervision of staff who provide ABA services) was revised to include the qualifications of an individual who provides supervision to staff providing ABA services, the Department does not believe that it is necessary to include a definition of "qualified individual" in the rulemaking.

§ 5240.2 Definitions – ASD—Autism spectrum disorder

IRRC and one commentator noted that the definition of "autism spectrum disorder" differs from the definition of "autism spectrum disorder" found in 49 Pa. Code § 18.522 (relating to definitions) and requested that the Department explain why it used a definition different from the definition used in the State Board of Medicine's regulations governing behavior specialist licenses.

Response:

While the Department did use a different definition of "autism spectrum disorder," the definitions in 49 Pa. Code § 18.522 (relating to definitions) and the definition used in this rulemaking are consistent. The definition included in this rulemaking includes a greater focus on the behaviors associated with ASD because IBHS are intended to treat maladaptive behaviors by decreasing them and increasing adaptive behavioral skills.

§ 5240.2 Definitions – Aversive conditioning, chemical restraint, mechanical restraint, pressure-point technique and seclusion

The Department identified in the final-form rulemaking the restrictive procedures providers are not permitted to use, which include seclusion, aversive conditioning, pressure-point technique, chemical restraint and mechanical restraint. As a result, the Department has added definitions of "seclusion," "aversive conditioning," "pressure-point technique," "chemical restraint" and "mechanical restraint" to the final-form rulemaking.

§ 5240.2 Definitions – Community like setting

The Department has added a definition of "community like setting" to the final-form rulemaking to clarify where group services can be provided. The Department has defined "community like setting" as "[a] setting that simulates a natural or normal setting

for a child, youth or young adult." A community like setting can be at an IBHS agency's site, but the setting where group services are provided must be designed in such a manner as to appear to be a natural or normal setting for a child, youth or young adult.

§ 5240.2 Definitions – Trauma-informed approach

Two commentators recommend including "traumatization" in addition to "retraumatization" in the definition of "trauma-informed approach."

Response:

The Department does not agree that it is necessary to include "traumatization" in the definition of "trauma-informed approach" because the definition already includes language about the impacts of trauma and practices to avoid traumatization.

§ 5240.2 Definitions – Treatment team

The Department has added a definition of "treatment team" to the final-form rulemaking to clarify who can be involved in a child's, youth's or young adult's treatment. A child's, youth's or young adult's treatment team may include the child, youth, young adult, parents, legal guardians, caregivers, teachers, individuals who provide services and any individual chosen by the child, youth, young adult, parents or legal guardians.

Scope of benefits

§ 1155.11 Scope of benefits

IRRC requested that the Department define the term "behavioral health diagnosis" and asked the Department to clarify if the term "behavioral health diagnosis" excludes children, youth and young adults with an intellectual disability. Another commentator stated that IBHS cannot be limited to children, youth and young adults with a behavioral

health diagnosis and for clarity the rulemaking should be revised to state that a child, youth or young adult must have a diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Disease (ICD) to be eligible for IBHS.

Response:

A behavioral health diagnosis requires a child, youth or young adult to meet the diagnostic criteria established in the current version of the DSM or ICD for a mental health or behavioral disorder. A child, youth or young adult with an intellectual disability would be eligible to receive IBHS if the child, youth or young adult has behaviors that meet the level of severity to meet the criteria for a mental health or behavioral disorder.

IRRC noted that since "young adult" is defined as a person who is "under 21 years of age," the Department should delete the phrase "under 21 years of age" from all subsequent references to young adults in the rulemaking.

Response:

The Department has deleted the phrase "under 21 years of age" from subsequent references to young adult in the rulemaking.

Participation requirements

§ 1155.21 Participation requirements, § 1155.22 Ongoing responsibilities of providers

IRRC asked the Department to explain the difference between being licensed and enrolled and requested that the Department clarify the difference in the final-form rulemaking.

Response:

An IBHS agency must obtain a license. However, if the provider wants to participate in the MA Program, the provider must obtain a license and enroll in the MA Program.

IRRC noted that § 1155.22(e) (relating to ongoing responsibilities of providers) requires an IBHS agency to notify the Department if the agency has changed its name, address or service provided. IRRC questioned if any of these changes will require Department approval, particularly if they differ from what was listed in the license or enrollment application.

Response:

The Department revised this requirement in the final-form rulemaking because § 5240.5(b) (relating to service description) addresses updates to service descriptions. However, providers are required to advise the Department of changes to the information in their MA enrollment applications.

Written order

§ 1155.32 Payment conditions for individual services, § 1155.33 Payment conditions for ABA services, § 1155.34 Payment conditions for group services, § 1155.35 Payment conditions for EBT delivered through individual services, ABA services or group services

IRRC and four commentators asked which licensed professionals, besides the licensed professionals identified in the rulemaking qualify to diagnose and treat behavioral health disorders. One commentator indicated that it would be better if the rulemaking identified the acceptable licenses. Another commentator shared concerns about broadening the types of licensed individuals who can prescribe IBHS and

requested that who can prescribe IBHS remain limited to who is allowed to prescribe BHRS.

Response:

The Department has chosen not to identify all of the specific licenses required to be able to prescribe IBHS because this may change over time and the Department cannot anticipate what other licenses may be created in the future that include within their scope of practice the diagnosis and treatment of behavioral health disorders or if the scope or practice of existing licenses will be changed. The Department will address this in provider training.

Fifteen commentators requested clarification if physical medicine physicians, such as developmental pediatricians and neurologists, may write an order for behavioral health services, such as ABA services.

Response:

Because they are licensed physicians, physical medicine physicians may write an order for behavioral health services, including ABA services.

Two commentators asked if payment will still be made for IBHS if an unlicensed person writes the order for IBHS and a licensed prescriber signs off on the order. Similarly, two other commentators asked if psychological associates can complete the written order.

Response:

Licensed individuals must follow the regulations that govern their license and should only sign off on tasks performed by an unlicensed individual, including psychological associates, if they are allowed to by their licensing regulations.

One commentator stated that agencies that deliver IBHS should not also prescribe the hours of IBHS needed because this creates a conflict of interest.

Response:

Individuals who can prescribe IBHS are bound by their professional ethics and should not prescribe hours of service a child, youth, or young adult does not need. If it is believed that a prescriber is acting unethically, it should be reported to the prescriber's licensing board.

One commentator stated that only psychologists and psychiatrists are qualified to perform evaluations and the commentator is concerned that other practitioners do not have the same level of specialized training as a psychologist or psychiatrist.

Response:

The Department believes that other individuals who have a license whose scope of practice includes the diagnosis and treatment of behavioral health disorders are qualified to write an order for IBHS.

One commentator expressed concern about lowering the credentials for evaluators who can prescribe ABA services because the commentator believes it is difficult to properly diagnosis children, youth and young adults who are part of a specialty population, including children, youth or young adults with ASD, social language disorder, depression, reactive stress disorder, post-traumatic stress disorder or attachment disorder.

Response:

The Department does not agree that it is lowering the standard for who can prescribe ABA services. The Department is allowing licensed individuals whose scope of practice

includes the diagnosis and treatment of behavioral health disorders to prescribe ABA services. The Department expects that this will include individuals who specialize in treating and diagnosing the populations identified by the commentator.

One commentator asked if individuals who prescribe ABA services should also have a certification related to ABA.

Response:

The Department believes that such a requirement is unnecessary and would unduly restrict access to ABA services. A licensed professional whose scope of practice includes the diagnosis and treatment of behavioral health disorders is able to determine if a child, youth or young adult needs ABA services.

One commentator asked if an order for IBHS can be written by a physician assistant.

Response:

A licensed professional whose scope of practice includes the diagnosis and treatment of behavioral health disorders may write an order for IBHS. If the scope of practice of the physician supervising the physician assistant includes the diagnosis and treatment of behavioral health disorders, the physician assistant may write an order for IBHS.

One commentator stated that the rulemaking does not mention where a written order originates and what authorization process for services, if any, must be followed.

Response:

The written order must be written by someone who satisfies the requirements in §§ 1155.32-1155.35. The rulemaking does not establish the authorization process, if any, that must be followed. The Department and the BH-MCOs will establish this process and will provide further information on the process once established.

One commentator requested confirmation that a best practice evaluation would meet the written order requirements. This commentator also asked if a prescription letter meets the written order requirements.

Response:

The requirements for a written order included in the final-form rulemaking must be complied with regardless of the format used for the written order. Acceptable formats include an evaluation or a prescription letter as long as the requirements for a written order included in the rulemaking have been met

IRRC and one commentator questioned if the assessment is to be done in place of a psychological evaluation, or if both are required. Another commentator stated that a face-to-face evaluation by a licensed practitioner of the healing arts that results in a prescription for a covered service is the basis for billing MA for services. This commentator believes the requirement in the rulemaking for an order undermines this premise.

Response:

The Department does not agree that an evaluation is necessary for MA to pay for IBHS. The rulemaking allows a graduate-level professional to conduct an assessment of the child, youth or young adult in the home and community, which can support or supplant components of an office-based evaluation. The rulemaking also does not preclude a qualified individual from providing a medically necessary evaluation.

One commentator stated that eliminating the best practice evaluation will likely help expedite access to services and asked if it is intended that the written order only contain

a prescription for services and if the assessment will be used to determine the locations of service, as well as the hours of service needed in each location.

Response:

The written order must contain the elements listed in the rulemaking, including the maximum number of hours of each service recommended a month for the child, youth or young adult. The assessment of the child, youth or young adult is intended to provide more specifics regarding treatment delivery, including the number of hours of each service needed at each location. The assessment is also intended to guide the development of the ITP. An evaluation of the child, youth or young adult can still be conducted.

One commentator advocated that for a prescriber to complete the written order, the prescriber must have a face-to-face interaction with a parent or caregiver and if a face-to-face interaction is not possible, a parent or caregiver should at least be consulted.

Response:

Prescribers can have face-to-face interactions with a parent, legal guardian or caregiver even though the rulemaking does not require it. The Department has not made a face-to-face interaction between the prescriber and a parent, legal guardian or caregiver a requirement because it may not always be clinically appropriate for the prescriber to interact with a parent, legal guardian or caregiver and because young adults are able to access IBHS without parental or caregiver involvement.

One commentator stated that an increased emphasis on the evaluation as a requirement of the prescribing professional would add value for the prescribing professional and to the development of the initial ITP.

Response:

The Department expects a prescriber's face-to-face interaction with a child, youth or young adult to be an evaluation, which allows the prescriber to obtain the information needed for the written order. The prescriber can conduct the face-to-face interaction in any manner that would allow the prescriber to obtain the information needed to complete the written order.

One commentator stated that a best practice evaluation is critical and is concerned that a written order will not be sufficient. The commentator believes that assessments are not an adequate replacement for best practice evaluations. Similarly, another commentator believes this rulemaking is attempting to eliminate the use of best practice evaluations.

Response:

The final-form rulemaking does not prevent an evaluator from performing an evaluation.

One commentator asked if the written order can include the maximum number of hours of services per week instead of the maximum number of hours of each service each month.

Response:

Because weekly is encompassed within the requirement of monthly, a recommendation for services that includes the maximum number of hours of services per week would be acceptable when the maximum number of hours per month is also included. The Department is requiring that the maximum number of hours per month be

included in the written order to promote consistency and allow for treatment to be based on clinical needs, which may vary throughout the month.

Two commentators requested information on what needs to be included in a written order for initiation and reinitiation of services.

Response:

Initiation and reinitiation of services can occur as long as there is a written order that meets the requirements listed in § 1155.32(a)(1)(iv) (relating to payment conditions for individual services) or § 1155.33(a)(1)(iv) (relating to payment conditions for ABA services).

One commentator asked if psychologists are expected to "rubber-stamp" prescriptions written by others who do not have the necessary credentials to conduct an evaluation. The commentator also questioned if the rulemaking should have included what is required to be in the written order because this impinges upon the practice of psychology.

Response:

The Department does not expect a psychologist or any other prescriber to "rubber-stamp" a written order. Psychologists and other licensed professionals must continue to operate within the standards, guidelines and ethics set forth by their licensing boards and the regulations that govern their practice. The Department does not agree that specifying what must be in a written order infringes on the practice of psychology. The Department is not directing a psychologist or other licensed professionals regarding the individual's clinical practice. A psychologist can obtain the information required to be included in the written order in any manner the psychologist believes appropriate,

including an evaluation, as long as the method used includes a face-to-face interaction with the child, youth or young adult.

Four commentators asked if the Department will train evaluators to collect the information needed for the written order for services. One commentator pointed out that the rulemaking requires information in the written order that is much more detailed than what is currently required in an order and questioned how evaluators will know what to include in the written order. Similarly, four other commentators requested clarification and additional information on the admissions process for IBHS, including the expectations regarding coordination between providers, the differences between the proposed requirements and the current practice of requiring an evaluation and further information on the minimum content of the order.

Response:

The Department will be providing training on the written order. It will address during the training what must be included in the written order and how provider coordination should occur during the admission process. The Department will also issue additional guidance documents on the written order and the admission process for IBHS, if necessary.

One commentator asked if there can be a range of hours included in the written order since the requirement is for a maximum number of hours per month.

Response:

The prescriber should not include a range of hours in the written order. The written order should state the maximum number of hours a prescriber has concluded is medically necessary.

One commentator requested further information on what must be included in the clinical information to support the medical necessity of each service ordered.

Response:

The clinical information needed to support the medical necessity of a service depends on the needs of the child, youth or young adult being served.

One commentator requested the Department provide a template to be used so that the written orders are standardized.

Response:

The Department does not believe that it is necessary that written orders for services be standardized. The final-form rulemaking specifies what is needed to be included in a written order.

Two commentators asked if a new written order is required if as a result of the assessment it is determined that a child, youth or young adult needs more or less hours of service than indicated in the written order. One commentator asked if it is necessary for the prescriber to conduct a reevaluation, is another face-to-face interaction required.

Response:

If as a result of an assessment it is determined that the child, youth or young adult needs a different number of hours of service than is included in the written order, the prescriber should be notified so the prescriber can review the additional information and determine if another face-to-face interaction with the child, youth or young adult is necessary. If it is determined that a child, youth or young adult needs less hours than indicated in the order, a new written order is not needed. If a child, youth or young adult needs more hours than indicated in the written order, a new written order is required.

One commentator asked if a primary care physician writes an order for an extensive amount of services, must the provider provide all ordered services when the child, youth or young adult does not appear to need the amount of services ordered. The commentator also asked if the written order should be considered a guide for services until the assessment and ITP are completed. Finally, this commentator asked what the next steps are if the assessment results in a determination that other services should have been prescribed.

Response:

The assessment process may lead to additional information that the prescriber may find helpful when determining the service recommendations that should be included in the written order. If the assessment determines that there is a different amount of services required than is included in the written order or that other services should have been prescribed, the treatment team should convene to resolve the discrepancy.

Treatment can start once there is a written order for IBHS, but a treatment plan needs to be developed to guide the services provided. The treatment plan does not need to include all of the information required by § 5240.22 (relating to individual treatment plan), § 5240.86 (relating to individual treatment plan), § 5240.96 (relating to individual treatment plan) and § 5240.102 (relating to assessment and individual treatment plan).

One commentator asked why orders for ABA services can be written within 12 months prior to the initiation of ABA services and orders for non-ABA services must be written within 6 months prior to the initiation of the services. The commentator recommends that for ABA services the requirement be changed to require a new written order every 6 months. Another commentator recommends the requirement for a written order be

consistent across services and recommends the time frame for a written order for all services be every 12 months.

Response:

The Department agrees that the time frame should be consistent across all services and has changed the minimum requirement for written orders to at least every 12 months for all IBHS. The Department believes that a written order for services every 12 months is sufficient because the ITP will guide treatment and the ITP is reviewed every 6 months. If this process reveals the need to update an order, it can be updated as needed.

Seven commentators requested information on how often reevaluations must occur and what information must be included in a reevaluation. Similarly, two other commentators asked if there is a standard length of care and how the length of care will be known if there is no requirement for ISPT meetings.

Response:

For payment for IBHS, there must be an order written within 12 months prior to the initiation of services. The information included in the written order may be the result of an evaluation, reevaluation or another similar process. The requirement that an order for services be written 12 months prior to the initiation of services does not preclude more frequent written orders for services or more frequent evaluations or reevaluations of the child, youth or young adult. There is no standard for how long services can be delivered because this is determined by the individual needs of the child, youth or young adult.

One commentator requested confirmation that the written order requirements also apply to group services.

Response:

The requirements for written orders for group services are included in § 1155.34 (relating to payment conditions for group services) and § 5240.94 (relating to group services initiation requirements).

One commentator believes that it is problematic to require that the order include a maximum number of hours and the setting where services may be provided because the assessment may conclude that a lesser amount of services are needed or a setting identified in the written order for where services should be provided is not a setting where services are needed. The commentator indicated that when this sort of discrepancy happens, it sometimes causes friction with the family. The commentator suggested that the written order recommend an assessment for IBHS and the licensed professional who conducts the assessment should recommend the number of hours of services that should be provided and where services should be provided. Finally, the commentator questioned what happens if there is a discrepancy between the written order and the assessment and the family wishes to dispute this discrepancy.

Response:

The Department does not agree that this will cause friction with the family. The assessment process may lead to additional information that the prescriber may find helpful when determining the service recommendations that should be included in the written order. If there is a disagreement between the amount of services prescribed in

the order and the amount of services the assessment determined are needed, the treatment team, which includes the family, should convene to resolve the discrepancy.

One commentator requested that the written order require that a recommended service also have an approved service description, as evaluators sometimes recommend services that do not exist in the geographical location where the child, youth or young adult lives.

Response:

The Department appreciates the desire for a written order to include services that are available where the child, youth or young adult lives. The Department suggests that an evaluator be familiar with services that are available in the geographical area where the child, youth or young adult lives.

Assessment

§ 1155.32 Payment conditions for individual services, § 1155.33 Payment conditions for ABA services, § 1155.34 Payment conditions for group services, § 1155.35 Payment conditions for EBT delivered through individual services, ABA services or group services, § 5240.21 Assessment, § 5240.85 Assessment, § 5240.95 Assessment, § 5240.102 Assessment and individual treatment plan

The Department has deleted from § 1155.32 (relating to payment conditions for individual services) and § 1155.33 (relating to payment conditions for ABA services) the reasons assessments must be reviewed and updated because a face-to-face assessment must be reviewed and updated within 12 months of the previous face-to-face assessment for payment to be made for IBHS.

One commentator questioned why the individual services section of the rulemaking does not include a cross reference to § 5240.21 (relating to assessment) to identify that it applies to individual services or separate sections that discuss the requirements for assessment as is done for ABA services, group services and EBT.

Response:

Section 5240.21 (relating to assessment) specifies which services it does not apply to in whole or in part and does not state that it does not apply to individual services. Because § 5240.21 applies to individual services, there is no need for a separate section that discusses the requirements for assessments for individual services.

IRRC requested that the Department clarify if the MA Program will pay for services if an IBHS agency does not complete the assessment within an indicated time frame.

Response:

The IBHS agency must complete the assessment within the time frames included in the final-form rulemaking to be paid. This is consistent with payment conditions included in other Department regulations.

Eight commentators requested that a definition of assessment that includes what comprehensive means and the specific requirements for an assessment be included in the rulemaking.

Response:

The Department has removed the word "comprehensive" from the rulemaking because it was confusing and there is no need to include it. What must be included in an assessment is identified in the rulemaking. The Department will not be including a definition of assessment in the rulemaking because children, youth and young adults

who receive IBHS have a variety of needs and diagnoses, and therefore, there is no definition that would encompass all situations. Generally, a mental health assessment is a process that is used to ascertain whether an individual is functioning on a healthy psychological, social or developmental level. Because the assessment process is used to inform the writing of a child's, youth's or young adult's ITP, the assessment must be completed in a manner that allows for an informed ITP to be written.

IRRC and three commentators asserted that it is inappropriate for an assessment to be completed by a person who does not have a professional license and requested that the final-form rulemaking require that an assessment be done by a licensed professional or under the supervision of a licensed professional. IRRC also requested that the Department explain how the health, safety and welfare of children, youth and young adults will be protected by the level of expertise and experience of the person assessing them.

Response:

There is no need to limit who can conduct an assessment to licensed professionals because individuals other than licensed professionals are trained to conduct assessments. In addition, an assessment is not a separate service, but rather assessing a child, youth or young adult is part of behavior consultation services, mobile therapy services, behaviors consultation-ABA services, behavior analytic services and a component of the services a graduate-level professional provides when providing group services. Individuals who provide behavior consultation services, mobile therapy services, behaviors consultation-ABA services, behavior analytic services and graduate-level professionals who provide group services will have received training in completing

assessments as part of obtaining their graduate-level qualifications and are supervised by licensed clinical directors.

Three commentators questioned why the Department limited the individuals who could complete an assessment to the individuals who provide the direct services, rather than also allowing a supervisor or another qualified individual to perform the assessment.

Response:

The final-form rulemaking was updated to clarify the minimum qualifications for an individual to conduct an assessment. Individuals who conduct assessments no longer need to provide the direct services.

Two commentators requested that a requirement for face-to-face participation by the child's, youth's or young adult's family in the assessment process be added to the rulemaking.

Response:

As a result of the variance in family dynamics, clinical focus and types of assessments used, family participation in an assessment may not always be warranted. The rulemaking does provide that the assessment should include the strengths and needs of the family system in relation to the child, youth and young adult and clinical information related to family structure and history.

Two commentators asked how the assessment process works when services need to be provided during the assessment period.

Response:

The Department has revised §§ 1155.32 - 1155.35 and § 5240.23 (relating to service provision) to clarify that IBHS can be provided during the assessment process if needed if there is a written order for services and there is a treatment plan for the services that will be provided.

One commentator asked if the Department will be developing its own assessment tool for EBT or if the tool developed for the EBT may be used.

Response:

The Department will not be developing assessment tools. Providers should use an assessment developed for the EBT if such an assessment tool has been developed. If no assessment has been developed for the EBT, the provider should use a clinically appropriate assessment.

Five commentators questioned why different time frames for completion of the assessment were used for each IBHS and suggested that there be a consistent time frame for completing the assessment for all services. In addition, two commentators stated that 5 days was too short to complete an assessment for group services, especially if the assessment is for STAP. IRRC and five commentators questioned why there was no time period included for completion of an assessment for ABA services. In addition, IRRC noted that commentators asserted that 15 days is too short for completing an assessment because a family's schedule could be a challenge.

Response:

The Department understands the concerns expressed by IRRC and the commentators and has revised the rulemaking to include consistent time frames for the completion of the assessment for individual services, group services and EBT. All

assessments must be completed for children, youth and young adults receiving these services within 15 days of the initiation of services. The Department has also added a requirement that the assessment be completed within 30 days of the initiation of ABA services. Additional time is allowed for an assessment when ABA services are provided because ABA services require more extensive initial data collection and analysis. Providers have confirmed to the Department that these revised time frames are feasible.

Six commentators asked that the Department clarify how the time frame for completing the assessment will be calculated and expressed concerns about the calculation of the time frames being tied to the written order for services.

Response:

The time frame for completing an assessment is measured from the date of initiation of services, which can include the first day a staff person begins to conduct an assessment if that is the first service a child, youth or young adult receives. Calculation of the time frame for completing the assessment is not tied to the written order for services.

Two commentators questioned why an assessment needs to be updated if one goal had been reached.

Response:

The Department agrees that it may not be necessary to update an assessment if the child, youth or young adult has completed one goal. The Department has revised the final-form rulemaking to state that an update is needed when a child, youth or young adult "has made sufficient progress to require an updated assessment."

Two commentators asked how often an assessment must be updated if none of the reasons included in the rulemaking for updating as assessment apply. One commentator asked the same question, but specifically for ABA services.

Response:

If an updated assessment is not required sooner, the assessment must be updated annually for all services.

Two commentators stated that input from individuals other than IBHS agency staff is not sufficient to require an update to the assessment.

Response:

The Department agrees and has updated the language in § 5240.21(e)(7) (relating to assessment) and § 5240.85(e)(7) (relating to assessment) to require that the individual who has requested an update "provides a reason" the update is needed.

One commentator asked if § 5240.21(e)(7) (relating to assessment) includes individuals from the BH-MCOs. IRRC requested that the Department clarify who qualifies as an "other professional involved in the child's, youth's or young adult's services" that is able to request an update to an assessment.

Response:

Because individuals from a BH-MCO are "involved in the child's, youth's or young adult's services," if they provide a reason an update is needed, an assessment will be updated. Any individual who is involved in a child's, youth's or young adult's treatment may request that an assessment be updated and the assessment will be updated if the individual provides a reason it is needed.

Four commentators had questions regarding signatures. IRRC and one commentator asked whether parents or caregivers should be required to sign the assessment and two other commentators questioned the need for a supervisor to co-sign the assessment.

Response:

The Department does not believe it is necessary for the assessment to be signed because the assessment is used to complete the ITP and the ITP must be signed by the youth, young adult, or a parent or caregiver of a child or youth and an individual who meets the qualifications of a clinical director. The Department has deleted from the rulemaking the requirement that a supervisor of the staff person who completed the assessment or a clinical director sign the assessment.

One commentator asked if a child, youth or young adult is not progressing, can the ITP be updated without an assessment being conducted.

Response:

If a child, youth or young adult has not made progress towards the child's, youth's or young adult's goals within 90 days of initiation of services, another assessment must be conducted before an ITP can be updated.

Individual treatment plan

§ 1155.32 Payment conditions for individual services, § 1155.33 Payment conditions for ABA services, § 1155.34 Payment conditions for group services, § 1155.35 Payment conditions for EBT delivered through individual services, ABA services or group services, § 5240.22 Individual treatment plan, § 5240.86 Individual treatment plan, §

5240.96 Individual treatment plan, § 5240.102 Assessment and individual treatment plan

The Department has removed from § 1155.32 (relating to payment conditions for individual services) and § 1155.33 (relating to payment conditions for ABA services) the requirement that payment be made if the ITP has been reviewed and updated because an ITP goal is completed; no significant progress is made within 90 days from the initiation of services identified in the ITP; a youth or young adult requests a change; a parent or caregiver of a child or youth requests a change; the child, youth or young adult experiences a crisis event; the ITP is no longer clinically appropriate for the child, youth or young adult; or an IBHS agency staff person, primary care physician, other treating clinician, case manager or other professional involved in the child's, youth's or young adult's services recommends a change. The Department has removed this requirement because regardless of the reason for the review, the ITP must be reviewed and updated within 6 months of the previous ITP for payment to be made for services.

Section 5240.22 (relating to individual treatment plan), § 5240.86 (relating to individual treatment plan) and § 5240.96 (relating to individual treatment plan) continue to include the reasons an ITP would need to be reviewed and updated sooner than 6 months after its completion. The Department has revised the requirement that the ITP be updated if a goal is completed because it may not be necessary to update an ITP if the child, youth or young adult has completed one goal. The final-form rulemaking states that an ITP must be updated if a child, youth or young adult "has made sufficient progress to require that the ITP be updated." In addition, the Department has added a requirement that the

ITP be updated if the child, youth or young adult experiences a change in living situation that results in a change of the child's, youth's or young adult's primary caregivers.

The Department has also removed the requirement that the ITP include the type of staff providing the services because it is not necessary. The qualifications of the staff that can perform a service are included in the final-form rulemaking. In addition, to be consistent with the requirements for ITP for other IBHS, the Department has added the requirement that an ITP for ABA services include a safety plan to prevent a crisis, a crisis intervention plan and a transition plan.

One commentator questioned why the individual services section of the rulemaking does not include a cross reference to § 5240.22 (relating to individual treatment plan) to identify that it applies to individual services or separate sections that discuss the requirements for ITPs as is done for ABA services, group services and EBT.

Response:

Section 5240.22 (relating to individual treatment plan) specifies which services it does not apply to in whole or in part and does not state that it does not apply to individual services. Because § 5240.22 applies to individual services, there is no need for a separate section that discusses the requirements for ITPs for individual services.

IRRC requested that the Department clarify if an IBHS agency can be paid if an ITP is not completed within an indicated time frame.

Response:

The IBHS agency must complete the ITP within the time frames included in the final-form rulemaking to be paid. This is consistent with payment conditions included in other Department regulations.

One commentator stated that in order to close the loop between treatment and assessment, psychologists and other licensed professionals should be involved in updating the ITP.

Response:

The Department agrees that it would be beneficial for a psychologist or other licensed professional to be involved in updating the ITP, but does not believe that their participation should be required because their participation may not always be clinically indicated. In addition, psychologists and other licensed professionals may be involved in a child's, youth's or young adult's treatment through other means, including providing written recommendations for services or treatment.

One commentator requested that the Department consider extending the time frame for completion of the ITP because 30 days is not enough time to complete the ITP.

Response:

The child, youth or young adult will have an assessment completed prior to the development of the ITP that can be used to complete the ITP. The Department does not agree that the time frame for completing the ITP is not sufficient because an ITP is needed to guide the services a child, youth or young adult receives.

The Department is allowing 45 days for completion of the ITP after the initiation of ABA services because the Department has allowed an additional 15 days for completion of an assessment when ABA services are being provided. The Department has also changed the time frame for completing an ITP for group services from 10 days to 30 days after the initiation of group services, to align the time frame for completing an ITP for groups services with the time frame for completing an ITP for individual services.

IRRC requested that the Department explain the term "strength-based."

Response:

Strength-based treatment planning is standard practice in the behavioral health community. Strength-based treatment means that a child's, youth's or young adult's strengths are incorporated into the ITP. For example, if a child enjoys writing, the ITP may include as a strategy to cope with anxiety that the child should write the child's concerns in a journal. The Department does not believe that an explanation is needed in the final-form rulemaking.

IRRC and one commentator requested that the Department clarify the terms "crisis" and "crisis intervention plan."

Response:

The Department has not defined "crisis" in the rulemaking because what constitutes a crisis depends on the child, youth or young adult. Each child's, youth's or young adult's crisis intervention plan should specify what is a crisis event for the child, youth or young adult and what interventions the treatment team members should use in the event of a crisis.

IRRC and four commentators asked why an ITP must include a transition plan.

Response:

The transition plan is needed because it is a plan to establish how a child, youth or young adult will resume the child's, youth's or young adult's regular activities after a crisis event.

Five commentators requested that the Department allow the ITP to include an estimate of the number of hours a service will be provided at a location to prevent the

requirement that the ITP include the number of hours of service at each setting from becoming a reason to deny services or otherwise becoming a problem for families.

Response:

The Department is requiring that the ITP specify the number of hours of services in each setting because the number of hours is determined after the assessment is completed, is based on clinical need and is used to guide the delivery of service.

One commentator stated that if the number of hours each service should be provided is not determined until the ITP is completed, it is unclear how the ITP relates to the prescription and what will be used to determine the medical necessity of services. This commentator believes that not determining the number of hours of services that can be provided until the ITP is completed will allow the provider to deliver as many hours of service as the provider wants and the number of hours of services a provider delivers could be influenced by financial gain, available staffing and other factors that have no relationship to the actual needs of the child, youth or young adult served.

Response:

The provider cannot deliver as many hours as the provider wants. The written order specifies a maximum number of hours for each service and is followed by an assessment of the child, youth or young adult. The number of hours a service should be delivered in each environment is determined by the assessment.

Three commentators requested clarification regarding when lack of progress or minimal progress would require that an ITP be updated.

Response:

The final-form rulemaking requires the ITP to be reviewed and updated at least every 6 months or if the child, youth or young adult has not made significant progress within 90 days from the initiation of the services identified in the ITP. What constitutes lack of significant progress will vary and should be determined by the treatment team.

One commentator questioned if individuals from the BH-MCO are included in the individuals that may provide a reason that an update to the ITP is needed. IRRC requested that the Department clarify who qualifies as an "other professional involved in the child's, youth's or young adult's services" that is able to request an update to an ITP.

Response:

Any individual who is involved in a child's, youth's or young adult's treatment, including individuals who are employed by a BH-MCO, may request that an ITP be updated and the ITP will be updated if the individual provides a reason it is needed.

One commentator requested that the Department require that an ITP update include a visual display of progress.

Response:

While the Department believes that is beneficial to include visual displays of progress in an ITP update, it is not mandating that they be used. A child's, youth's or young adult's progress can be reported through various means, including a graphical representation of progress, a narrative that includes data collected on the child's ITP goals or narrative reports from members of the treatment team.

Two commentators stated that they think that the ITP should reflect that there is a need for family involvement in treatment. One of the two commentators stated that by using the term "whether," the Department is not requiring parent, legal guardian or

caregiver participation, which contradicts best practice when treating a child and requested that the Department revise the requirement that the ITP include "whether and how parent, legal guardian or caregiver participation is needed to achieve the identified goals and objectives." The commentators believe that the final-form rulemaking should address how the parent or caregiver will participate in treatment.

Response:

The Department has not made the suggested change. Depending on the needs of the child, youth or young adult, participation by a parent, legal guardian or caregiver in treatment may not be needed.

Prior authorization

Two commentators asked which number of hours controls when determining if services are medically necessary, the number of hours included in the written order for service or the number of hours included in the assessment that follows the written order.

Response:

The number of hours included in the written order should be used when determining if services that require prior authorization are medically necessary. The information provided in the assessment should further supplement the information provided in the written order.

One commentator asked if the assessment must be submitted to the BH-MCO for prior authorization of an IBHS. Another commentator asked if the ITP must be submitted to the BH-MCO when there is a request to reauthorize services.

Response:

BH-MCOs are responsible for determining what must be submitted to support a request to prior authorize services.

Two commentators asked what credentials individuals who review a request for services on behalf of a BH-MCO must have to deny a request for IBHS because it is not medically necessary.

Response:

Only a licensed physician or a licensed psychologist whose scope of practice includes the requested service can deny a request for IBHS because it is not medically necessary. In addition, the individual must have appropriate clinical experience or expertise to render such a decision.

Two commentators asked how BH-MCOs will determine that services in the written order are medically necessary.

Response:

Each BH-MCO must determine the process and information it will require for review of prior authorization requests.

One commentator asked if services are initiated prior to being authorized and the service is subsequently denied, who is responsible for paying for the services.

Response:

The MA Program will not pay for services that require prior authorization if authorization was denied. BH-MCO members can file a grievance if authorization is denied.

Two commentators requested clarification on how services are authorized.

Response:

The Department and the BH-MCOs will issue guidance on how to request that services be authorized.

One commentator asked how assistant behavior consultation-ABA services are authorized and if they are prescribed at the discretion of the agency.

Response:

Assistant behavior consultation–ABA services will be authorized in the same manner as other IBHS. The prescriber must include a recommendation for assistant behavior consultation-ABA services in the written order.

Two commentators asked what BH-MCOs should use to determine the medical necessity of services requested in a written order.

Response:

The Department will be revising the medical necessity guidelines in Appendices T and S of the BH-MCO agreements to reflect the new requirements for prescribing IBHS.

Services provided prior to discharge from a facility

§ 1155.37 Limitations

Two commentators stated their support for payment for services provided to children, youth or young adults residing in 24-hour residential facilities provided within 60 days of discharge from the facility that assist in a child's, youth's or young adult's transition to the home or community setting. One commentator asked if there is an exception to the 60-day limit on payment for IBHS when a child, youth or young adult is transitioning from a 24-hour residential facility to the home or community setting.

Response:

The Department has revised the final-form rulemaking to remove the limitation that payment for IBHS will be made only within 60 days of discharge for a child, youth or young adult transitioning from a 24-hour residential facility to the home or community setting. Although generally the services provided by the residential facility will meet the needs of the child, youth or young adult there may be situations, in addition to assisting with the transition to the home or community, where IBHS is appropriate. IBHS can be provided to a child, youth or young adult residing in a 24-hour residential facility if the order explains why IBHS is needed in addition to services provided by the facility and the service does not duplicate services included in the facility's rate.

Licensing

The Department has added a requirement that licensed IBHS agencies must comply with Chapter 20 (relating to licensure or approval of facilities and agencies) to § 5240.3 (relating to provider eligibility). The Department always intended that IBHS agencies comply with Chapter 20 and added the requirement that an IBHS agency must comply with Chapter 20 to the final-form rulemaking to avoid any confusion.

One commentator asked if agencies are able to provide one service or if they will be required to provide all IBHS in order to obtain a license and if agencies can provide a distinct service at each IBHS agency site.

Response:

An agency may provide and be licensed to provide one service or multiple services and different services can be provided at different locations. Services other than group services may only be provided in the home, school and community. Group services

may also be provided at a community like setting, which is a setting that simulates a natural or normal setting for a child, youth or young adult.

Six commentators questioned how the Department plans to address services approved through the program exception process, including STAP, team-based programs and EBT programs.

Response:

Every agency that provides IBHS must obtain a license. The Department expects that most services that were approved through the program exception process will meet the requirements for individual services, ABA services or group services. If there is a requirement that cannot be met, the IBHS agency can request a waiver of the requirement pursuant to § 5240.111 (relating to waivers). Payment will also be made for services as indicated in § 1155.36(5) (relating to covered services) if the service has been approved through the program exception process under § 1150.63 (relating to waivers).

One commentator requested that providers that are currently providing group services be allowed a transition period to come into compliance with the rulemaking.

Response:

Providers will need to comply with this rulemaking 90 days after its promulgation.

Two commentators requested that the Department provide information about the annual licensing inspections, including the qualifications needed to obtain a license and process to obtain a license to provide IBHS, the utilization management reviews and who will be conducting the licensing inspections. One commentator asked for additional information regarding what will be reviewed as part of licensing an IBHS agency.

Response:

The Department will be providing training and technical assistance to providers about the licensing process. In addition, training and technical assistance will be offered during each agency's initial licensing inspection. OMHSAS licensing staff will be conducting the licensing inspections.

Five commentators questioned whether this rulemaking applies to licensed psychologists.

Response:

Licensed individuals who provide services directly within the scope of their license do not need to obtain an additional license to provide IBHS or to receive payment for psychological services. For example, a psychologist who provides behavioral interventions within the scope of the psychologist's license does not need to obtain an IBHS license to continue to provide services to a child, youth or young adult. However, if staff employed by the psychologist provide BHT services, the psychologist's agency would need to obtain an IBHS license. In order to clarify when a licensed psychologist must obtain a license to provide IBHS, the Department has added the word "directly" to § 1155.1(c) (relating to policy).

IRRC and seven commentators requested that the Department clarify what constitutes a branch or satellite site and questioned why an IBHS agency's branch location or satellite site in addition to its main facility must obtain a license.

Response:

The Department has removed from § 1155.22 (ongoing responsibilities of providers) the requirement that a branch or satellite location must obtain a license or be enrolled by the Department.

Two commentators requested that a county letter of support be added to the requirements to obtain a license.

Response:

The Department does not agree that a county letter of support should be required for an IBHS agency to obtain a license because such a letter would not address if an IBHS agency meets the minimum requirements to obtain a license.

Licensing time frames

§ 1155.31 General payment policy, § 5240.3 Provider eligibility

The Department received questions from eight commentators about the initial licensure time frames for IBHS agencies and whether services will be paid for prior to an IBHS agency obtaining a license. Questions included what are the time frames for obtaining a license, how agencies that do not currently hold an OMHSAS license will be notified that they must obtain a license within a certain time frame, why agencies already licensed by OMHSAS have more time to obtain an IBHS license, whether providers will have adequate time to come into compliance with the rulemaking and how the Department will ensure that services are not disrupted while IBHS agencies obtain licenses.

Response:

Agencies that are not currently licensed are the Department's priority. The Department intends to publicize the requirement to obtain a license and will follow up with providers who have not timely obtained a license.

New IBHS agencies must obtain a license within 90 days of the promulgation of this rulemaking and an unlicensed agency that is approved to provide ABA services must obtain a license within 180 days of the promulgation of this rulemaking. An IBHS agency that holds an outpatient psychiatric clinic license, a psychiatric partial hospitalization program license or a family based mental health license must obtain an IBHS license when its license expires. This will allow the provider to maintain its annual licensing time frame and allow OMHSAS time to license the provider. Finally, all other IBHS agencies that are currently approved to provide BHRS are required to obtain an IBHS license within 1 year of the promulgation of this rulemaking. The Department has revised the final-form rulemaking to clarify these requirements.

Regardless of when an IBHS agency obtains an IBHS license it can continue to receive payment for services if it complies with this rulemaking 90 days after its promulgation. The Department is allowing payment to be made to unlicensed agencies to ensure that children, youth and young adults do not lose services because an agency has not yet obtained a license.

Service descriptions

§ 5240.5 Service description

Because the Department has further clarified in the final-form rulemaking what services may be delivered through IBHS, the Department is no longer requiring that a service description include the purpose of the service being offered by the IBHS

agency, expected duration of the service and expected outcomes for children, youth or young adults.

Two commentators questioned if an agency will need to update its service description to obtain an IBHS license. They expressed concerns about the length of time the review process takes because of the need to work with the BH-MCOs and counties to ensure that the services that are provided are needed by the BH-MCO. They were also concerned about the amount of staff time required to complete a service description and any requested revisions or updates.

Response:

Agencies will need to update their service descriptions to obtain a license because some of the requirements for IBHS are different than the requirements for BHRS.

Four commentators requested that the role BH-MCOs and counties will have with regards to the approval of service descriptions be clarified. They questioned if BH-MCOs and counties will have input in the development of service descriptions.

Response:

The service description required for an IBHS agency to obtain a license does not require county or BH-MCO input or approval. If a provider wants to contract with a BH-MCO, the BH-MCO may also require a service description.

IRRC and seven commentators stated that the process for review of a service description does not appear to differ from the current process and questioned why the Department said that the process was less burdensome than the current process. IRRC and other commentators requested that the Department provide additional

guidance on the service description process or use a more standardized process that includes a template.

Response:

The Department will be following the same process to review service descriptions for IBHS as it does for other services that are provided by licensed providers. In the past the Department required providers to submit a service description to OMHSAS's Children's Bureau for each service the provider provided. The rulemaking requires that licensing staff review one service description that includes all of the services the provider provides.

The Department will provide training and technical assistance regarding the development of IBHS service descriptions. If a consistent delivery model is used, such as for an EBT, the Department may develop a template. Templates will not be developed for a service where there is a variety of ways the service can be provided.

Two commentators asked if a service description is needed for each program at each location and if separate service descriptions are needed when the same service is being provided at different locations.

Response:

A service description should include all the locations where a service will be offered and may include multiple services in one service description.

Two commentators suggested that the requirement that the service description include the maximum number of children, youth or young adults who may be assigned to an individual who provides BHT services or BHT-ABA services if BHT services or

BHT-ABA services will be provided be revised to also consider the number of hours of services ordered for the children, youth or young adults being served.

Response:

The Department has revised the final-form rulemaking and is no longer requiring that a service description include the maximum number of children, youth or young adults who may be assigned to an individual who provides BHT services or BHT-ABA services because this information can be ascertained from the staffing ratios for each service offered by the IBHS agency, which must be included in the service description. The Department has added a requirement that a service description include the maximum number of children, youth or young adults who will be served at the same time through group service at each community setting or community like setting.

Two commentators requested clarification about the requirement that the service description include staffing ratios for each service offered by the IBHS agency.

Response:

Staffing ratios must be included in a service description because they are needed to determine how a service will be provided and to ensure the service is appropriate for the clinical needs of the population being served.

Two commentators questioned how adherence to the service description will be monitored.

Response:

Service descriptions will be reviewed as a part of a licensing visit to confirm that the IBHS agency is providing services in accordance with its approved service description. During the licensing visit, the child's, youth's or young adult's ITP will be checked to see

if it reflects the services described in the service description. The Department also expects the agency to monitor adherence to the service description as part of supervision of staff. Supervisors should be confirming that staff are providing services consistent with the approved service description.

One commentator questioned if Multi Systemic Therapy (MST) can be provided as an IBHS.

Response:

An IBHS agency may provide MST. The agency will need to submit a service description based on the MST model that includes the information required by § 5240.5 (relating to service description).

IRRC requested that the Department explain the approval process for changes to the service description, the time frames that are involved and how the Department will notify the IBHS agency of its decision. IRRC asked the Department to include this process in the final-form rulemaking.

Response:

If an IBHS agency needs to change its service description, the IBHS agency should notify the Department. The Department suggests that this notification be by e-mail. The Department will notify the IBHS agency of its decision about the requested change. The amount of time needed for the Department to review a change to a service description will depend on the nature of the change and if revisions are needed by the IBHS agency. The Department will include information about this process in the training it will be providing to providers about the licensing process.

Restrictive procedures

§ 5240.6 Restrictive procedures

One commentator asked if the Department will be revising OMHSAS Bulletin-02-01, The Use of Seclusion and Restraint in Mental Health Facilities and Programs, because it currently prohibits the use of manual restraint by BHRS providers.

Response:

OMHSAS bulletin-02-01 provides that manual restraint is not expected to occur. It does not prohibit its use by BHRS providers. IBHS agencies will need to follow the provisions on restrictive procedures included in the final-form rulemaking.

Four commentators requested that the Department clarify which restrictive procedures may be used. The commentators wanted to know if manual restraints were the only type of restrictive procedure permitted.

Response:

The Department held a stakeholder meeting to discuss the public comments it received on the use of restrictive procedures. As a result of the discussion with stakeholders and the comments received, the Department has included in the final-form rulemaking the restrictive procedures providers are not permitted to use. Other restrictive procedures are permitted to be used if the requirements in this rulemaking for their use are met.

Three commentators requested that the Department remove the requirement that a second staff person who is not applying a manual restraint procedure observe and document the physical and emotional condition of the child, youth or young adult at least every 10 minutes during the application of a manual restraint. They stated that this may not be possible because services are delivered in a community-based setting.

Response:

The Department has revised this requirement in the final-form rulemaking. Rather than a second staff person being required to observe and document the use of a manual restraint, a trained individual must observe and document the use of a manual restraint. In addition to IBHS agency staff, a trained individual could be a member of the child's, youth's or young adult's treatment team.

Three commentators questioned if an IBHS agency can continue to maintain a restraint-free policy.

Response:

IBHS agencies can choose to be restraint free. The rulemaking has been updated to include that an IBHS agency that uses restrictive procedures shall have written policies and procedures for their use that identify the specific restrictive procedures that may be used and when they may be used.

One commentator questioned if informed consent is required for a restrictive procedure to be used.

Response:

Use of restrictive procedures should be discussed as a part of the child, youth or young adult's crisis plan. Informed consent would not be required in an emergency to prevent self-injury or injury to others after every attempt has been made to anticipate and de-escalate a behavior and less intrusive techniques and resources appropriate to the behavior have been tried but failed.

One commentator stated that staff should be required to receive training before implementing a manual restraint.

Response:

The rulemaking requires an IBHS agency to require yearly training for each staff person who administers a restrictive procedure.

One commentator recommended that the rulemaking require that the ITP be reviewed following the use of a manual restraint.

Response:

It is not necessary for the final-form rulemaking to include a requirement that the ITP be reviewed following the use of a manual restraint. Documentation of the use of a manual restraint is required to be included in a child's, youth's or young adult's record. The requirement to document the use of a manual restraint will result in the events that proceeded the use of the manual restraint and the use of the manual restraint being reviewed.

IRRC and one commentator suggested that the rulemaking align with the Department of Education's restrictive procedure requirements because BHT services are often provided in an educational setting.

Response:

IBHS are delivered in a variety of settings, including in school settings. The restrictive procedure requirements address the use of restrictive procedures in all settings where IBHS are provided.

IRRC and one commentator suggested that the language that addresses when a manual restraint should be discontinued be changed from "regain self-control" to "no longer an imminent danger to self or others" in § 5240.6(g) (relating to restrictive procedures) because a child, youth or young adult may not have regained self-control,

but the child, youth or young adult may no longer be engaging in behaviors that would warrant the use of a manual restraint.

Response:

The Department agrees and has revised the rulemaking to state that a manual restraint shall be discontinued when the child, youth or young adult is no longer an imminent danger to self or others.

One commentator stated that the rulemaking should prohibit the inappropriate use of manual restraint.

Response:

Section 5240.6(c) (relating to restrictive procedures) states when a manual restraint may be used. Any other use of manual restraint is prohibited.

In addition, the rulemaking requires an IBHS agency that uses manual restraints to have policies and procedures for the use of manual restraints that include the appropriate use of a manual restraint, including prohibitions on the use of a manual restraint; the required use of less intrusive techniques and resources appropriate to the behavior prior to the use of a manual restraint; and the immediate discontinuation of the manual restraint when the child, youth or young adult is no longer an imminent danger to self or others. The Department has also added a requirement to the final-form rulemaking that the policies and procedures include the staff who may authorize the use of a manual restraint and how the use of a manual restraint will be monitored.

Two commentators stated that IBHS agencies should be required to fully train parents and caregivers on the use of restrictive procedures because this will allow the family to implement the ITP when IBHS agency staff are not present. In addition, during

discussions with stakeholders several family members and advocates expressed that there is a benefit to being trained on restrictive procedures because this allows family members to continue to implement the child's, youth's or young adult's ITP and crisis plan when IBHS agency staff are not present.

Response:

After discussion with stakeholders, including a meeting that addressed only restrictive procedures, the Department has revised the final-form rulemaking to provide that an IBHS agency may choose to train parents, legal guardians or caregivers on the use of restrictive procedures that are included in the ITP. If an IBHS agency provides training to parents, legal guardians and caregivers the trainings must be approved by the Department and the agency must have policies and procedures that address the training. In addition, the ITP must include that parents, legal guardians or caregivers will be trained on the use of restrictive procedures.

One commentator requested that IBHS agencies be required to receive training from a nationally certified training program in the use of restrictive procedures and manual restraints.

Response:

The final-form rulemaking has been revised to provide that an IBHS agency must require yearly training that is approved by the Department for each staff person who administers a restrictive procedure, including a manual restraint. Nationally certified training programs may be approved by the Department, but there may be standardized training programs that are used on a local or regional level that provide sufficient training to warrant Department approval.

One commentator questioned how family members will be notified of the use of a manual restraint.

Response:

The Department has revised the final-form rulemaking to require that within 24 hours of the use of a manual restraint the IBHS agency must notify the treatment team. IBHS agencies' policies and procedures must include how the treatment team will be notified if a manual restraint is used.

IRRC requested that the Department clarify how long an IBHS agency must keep a record of a staff person's yearly training in the use of restrictive procedures and that a cross reference be added to the recordkeeping requirements in § 5240.42 (relating to agency records).

Response:

The Department has revised the final-form rulemaking to require that the record of each staff person's training in the use of restrictive procedures be kept in each staff person's personnel file in accordance with § 5240.42(b)(2) (relating to agency records). Section 5240.42(b)(2) requires that staff personnel records be maintained for at least 4 years after the staff person is no longer employed by the IBHS agency.

Coordination of services

§ 5240.7 Coordination of services

One commentator asked if a standardized document will be provided for providers to use for the written agreements to coordinate services with other service providers.

Response:

The Department will not be providing a template for the written agreement for coordination of services with other service providers. IBHS agencies need to develop their own agreements.

One commentator requested that IBHS agencies that also provide psychiatric inpatient and outpatient services, partial hospitalization services, crisis intervention services or case management services be exempt from having written agreements to coordinate services with other providers of these services.

Response:

IBHS agencies that also provide other services are not exempt from the requirement to have written agreements to coordinate services with other service providers because an IBHS agency must provide children, youth and young adults with a choice of provider. IBHS agencies are not precluded from including their own agency services as part of the community resources list required by § 5240.7(c) (relating to coordination of services).

One commentator asserted that requiring small ABA providers to have written agreements to coordinate services is an undue burden and should not be required. Six commentators requested that the Department require that IBHS agencies that provide group services must also have written agreements to coordinate services with other service providers.

Response:

The Department will not be exempting small ABA providers from having written agreements to coordinate services. Coordination of services is essential for all children, youth and young adults who receive IBHS because they often have multiple needs and

often receive services from different levels of care. The Department agrees that IBHS agencies that provide group services should be required to have written agreements to coordinate services with other service providers and has removed the exemption for these agencies from the final-form rulemaking.

One commentator asked for confirmation that an IBHS agency will not be held responsible if other providers do not respond to an IBHS agency's attempts to enter into a written agreement to coordinate services as long as the IBHS agency documents its attempt to engage with other service providers.

Response:

The Department confirms that it will not hold an IBHS agency responsible if other providers do not respond to the agency's attempts to enter into a written agreement to coordinate services and the IBHS agency documents its attempts to engage other providers.

One commentator asked if the Department had considered the cost of updating agreements with other service providers every 5 years.

Response:

The Department considers this cost as part of the overall administrative costs an IBHS agency will incur. The Department expects the costs the IBHS agency incurs as a result of this requirement will be minimal because of the infrequency of the requirement to update agreements and because it is common practice to update agreements with other service providers.

IRRC requested that the Department add to the information an IBHS agency must make available on community resources that provide behavioral health services a

requirement that the IBHS agency include the website of the community resources that provide behavioral health services.

Response:

The Department has not added this requirement to the final-form rulemaking because not all community resources have a website or the ability to create or maintain a website.

Service provision

§ 5240.23 Service provision

IRRC and one commentator requested that the Department clarify what is meant by the requirement in § 5240.23 (service provision) that IBHS shall be delivered in "community-based" settings and whether community-based settings include a home, school or other location.

Response:

"Community-based" means that services may be delivered anywhere children, youth or young adults would naturally be throughout their day.

One commentator asked if a family member or other individual involved with the child is allowed to participate in treatment if the child, youth or young adult is not present.

Response:

If included in the ITP, family members or other individuals involved with the child are allowed to participate in treatment even if the child, youth or young adult is not present if it will help the child, youth or young adult achieve a goal identified in the ITP.

Discharge

§ 5240.31 Discharge, § 5240.32 Discharge summary

Three commentators questioned what is required for a child, youth or young adult to be discharged from services, including if a child, youth or young adult who is not making progress after 90 days could continue to receive services or if a child, youth or young adult could be discharged for non-compliance or if the child, youth or young adult could be discharged for not participating in services.

Response:

The rulemaking does not mandate the discharge of a child, youth or young adult as a result of specified circumstances. It provides that a child, youth or young adult **may** be discharged from services if one of the reasons listed in the rulemaking occurs.

The Department has added to the final-form rulemaking that a child, youth or young adult may be discharged if the child, youth or young adult failed to attend scheduled IBHS for 45 consecutive days without any notification from the youth, young adult or the parent, legal guardian or caregiver of the child or youth and prior to discharge, the IBHS agency made at least three attempts to contact the youth, young adult or the parent, legal guardian or caregiver of the child or youth to discuss past attendance, ways to facilitate attendance in the future and the potential discharge of the child, youth or young adult for lack of attendance.

IRRC and 18 commentators expressed concern about the requirement that an IBHS agency may reinitiate services for up to 90 days if the condition of the child, youth or young adult has regressed and impacts the child's, youth's or young adult's ability to maintain functioning at home, school or in the community. The commentators questioned who would staff the services if they were reinitiated and staff had begun to serve other children, how reinitiated services would be authorized, what would be

required in the written order for services that were reinitiated, what to do if reinitiation of services was not consistent with an EBT's requirements and what are the requirements for new assessments and ITPs.

Response:

After discussing this topic with stakeholders, the Department has decided to remove from the final-form rulemaking the requirements relating to reinitiation of services. While generally stakeholders support the concept of allowing services to be reinitiated, there are problems with implementing this requirement. Stakeholders indicated that it would be difficult for IBHS agencies to reinitiate services if staff were no longer available to reengage with a child, youth or young adult or if there had been a change in the family's situation such as a move or change in custody. In addition, it would be difficult to reinitiate services when there has been a change in diagnosis, which may require a change in services.

The Department continues to support determining how best to assist children, youth and young adults who need to return to services for a brief time after discharge and intends to explore this issue further with stakeholders. In the meantime, there is nothing in the final-form rulemaking that precludes a child, youth or young adult from returning to services.

Two commentators asked who is qualified to write the discharge summary and one commentator requested that individuals in addition to the clinical director be allowed to sign the discharge summary.

Response:

The Department has added the following language to § 5240.32(a) (relating to discharge summary) of the final-form rulemaking: "An individual qualified to provide behavior consultation services, mobile therapy services, behavior analytic services or behavior consultation-ABA services must complete a discharge summary." Because the individual who writes the discharge summary must be a graduate-level professional, the agency's clinical director's signature on the discharge summary is not necessary.

IRRC and 25 commentators submitted comments about the requirement that the post discharge summary include documentation of at least two telephone contacts within the first 30 days after a child's, youth's or young adult's discharge to monitor the status of maintaining treatment progress. The commentators questioned who is responsible for making the phone calls, if letters could be substituted for phone calls, what is required if the discharge is unplanned, what to do if the IBHS agency is unable to reach the family, how many attempts must the IBHS agency make to contact the family, if attempts to contact the family and the telephone call are billable services, if discharge summaries would need to include information on post discharge phone calls, and how to address families who did not respond to contact attempts.

Response:

After discussing this topic with stakeholders, the Department has decided to remove the requirement that the post discharge summary include documentation of at least two telephone contacts within the first 30 days after a child's, youth's or young adult's discharge to monitor the status of maintaining treatment progress. While stakeholders believe post discharge phone calls have the potential to positively impact care, they were concerned that because of the volume of telephone calls a provider would be

required to make, the calls would not include a meaningful discussion of the child's, youth's or young adult's status or maintenance of treatment progress. Also, BH-MCOs, not providers, typically provide care management, and therefore, BH-MCOs should be following up after a child, youth or young adult is discharged from services. The county mental health program may also be involved with the child, youth or young adult. As a result, the Department will be removing the requirement for post discharge phone calls from the final-form rulemaking.

Records

§ 5240.41 Individual records, § 5240.42 Agency records, § 5240.43 Record retention and disposal

The Department has revised the record retention requirements to require an IBHS agency to retain a child's, youth's or young adult's records for at least 4 years after the last date of service. This change aligns the rulemaking with the requirements in § 1101.51(e) (ongoing responsibilities of providers), which require providers to maintain medical records for at least 4 years.

The Department has also included in the final-form rulemaking a requirement that if services are provided prior to the completion of the ITP, the child's, youth's or young adult's treatment plan must be included in the child's, youth's or young adult's record. The Department added this requirement to ensure that all pertinent records related to the treatment of the child, youth or young adult are included in the child's, youth's or young adult's record.

IRRC and ten commentators stated that requiring that the record for each child, youth or young adult an IBHS agency serves be reviewed every six months is excessive and suggested that a review of a sample of records should be required instead.

Response:

In response to these concerns, the Department has updated the language in the final-form rulemaking to require that a record be reviewed within the first 6 months of its initial entry and subsequent review may be limited to new additions to the records and must occur at least annually thereafter.

Three commentators requested that the requirement for having an emergency plan be removed because it was not a feasible requirement for providers that serve individuals in the community.

Response:

The Department consulted with providers that serve individuals in the community and they confirmed that an emergency plan was needed because emergencies occur when a provider serves a child, youth or young adult in the community. In addition, agencies that are accredited by The Joint Commission or COA are required to have emergency plans.

IRRC requested that the Department specify how long an agency must retain records related to its operations. IRRC also requested that the Department clarify if records can be maintained in electronic format.

Response:

The Department has added a requirement that agency records must be retained for at least 4 years. The Department chose 4 years because it is consistent with record

retention requirements included in other Department regulations. The Department does not address in the rulemaking how agency records are maintained, and as a result, an IBHS agency may choose the format it wants to use to maintain its records.

IRRC and one commentator questioned why agency records must include a daily schedule for group services if group services are provided and suggested that a sample schedule would be sufficient. IRRC also requested that the Department explain why IBHS agencies must keep records of staff work schedules.

Response:

A daily schedule is required because it is essential to guide staff and program operations. A sample schedule may be submitted as part of an IBHS agency's service description, but a schedule of daily activities must be available at the location where group services are provided. Records of staff work schedules must be maintained to ensure that individuals who provide services are receiving required supervision, to confirm that an IBHS agency is complying with the staffing requirements in this rulemaking and for program integrity reviews.

One commentator requested that the requirement to retain staffs' individual training plans be removed because it was overly burdensome.

Response:

The Department believes that it is important for IBHS agencies to retain a record of staff training plans to allow the agency to ensure that staff receive required trainings and the trainings address the staffs' needs.

Nondiscrimination

§ 5240.51 Nondiscrimination

Two commentators asked if the moral belief clause applies to this section.

Response:

Federal and state law, as well as the HealthChoices agreement, address the coverage of services.

Quality improvement

§ 5240.61 Quality improvement requirements

One commentator supported both the information required for the quality improvement plan as well as the requirement that the review and report be completed annually. One commentator asked the Department what mechanism will be used to account for the cost of the new quality improvement requirements.

Response:

Agencies that are currently accredited by entities such as The Joint Commission or the COA currently complete quality improvement plans as do the many providers licensed by OMHSAS. Given the common practice of utilizing quality improvement activities within organizations, the Department expects the cost of the new quality improvement requirements to be minimal.

One commentator stated the requirements in this section are too prescriptive and suggested that the provision be revised to contain language that provides the provider with more flexibility. In addition, the commentator asked that the quality management plan 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 and roles and

responsibilities of the staff persons related to the practice of quality management. One commentator asked for further clarification regarding what must be included in the annual review and report. IRRC asked that the Department define "quality improvement plan."

Response:

The Department does not believe it is necessary to define "quality improvement plan" because the Department has identified what must be included in the plan in § 5240.61(a)(1) (relating to quality improvement requirements). The Department also does not agree that additional requirements for what must be included in the quality improvement plan need to be added to the final-form rulemaking. The final-form rulemaking includes the minimum requirements for what must be included in a quality improvement plan. The quality improvement plan must explain how the IBHS agency will conduct an annual review that includes the items in § 5240.61(a)(1), addressing the specific information in § 5240.61(a)(2). The Department clarified some of the requirements in the final-form rulemaking.

Four commentators asked for further information regarding what must be shared with the public and how to address data so that it is not misconstrued due to a lack of understanding of the data. IRRC asked the Department to work with the regulated community regarding what information must be made available to the public.

Response:

The annual report is to include an analysis of the annual review, the elements of which are set forth in the final-form rulemaking. The annual report is available to the public, as stated in the final-form rulemaking. The Department will work with the

regulated community through stakeholder meetings and trainings to provide assistance regarding the content of the report, including providing information that would help individuals who are unfamiliar with data assessment and review to understand the report. For example, IBHS agencies might consider explaining individual and family satisfaction data.

Three commentators requested that the requirement for the quality report happen less frequently than annually. One commentator suggested that the quality improvement plan be reviewed at least annually and revised at least every 3 years.

Response:

The requirement for an annual review and report will remain. These are essential tools to be used by the IBHS agency and the Department in assessing the quality and delivery of services.

Two commentators asked for clarification regarding the staff qualifications to conduct the quality reviews.

Response:

Specific qualifications of the staff conducing quality reviews were not defined. The requirement is that the staff qualifications of those performing the review are included in the quality improvement plan.

One commentator asked that IBHS agencies be required to share the annual report with all HealthChoices primary contractors and HealthChoices oversight entities.

Response:

This rulemaking applies to IBHS agencies that may not be enrolled in the MA Program, and therefore the Department is not including this requirement in the final-form rulemaking.

Two commentators asked if there are standardized outcome measures. One commentator requested there be up to three standard outcome measurements that are to be used by all IBHS agencies so individuals and families have some form of comparison.

Response:

The Department has not defined standardized outcome measures due to the variety of ways IBHS agencies may choose to asses and review the quality of the services they provide.

One commentator noted that the BH-MCOs are not included in the quality improvement process.

Response:

This rulemaking applies to IBHS agencies that may not be enrolled in the HealthChoices program, and therefore the Department has not specifically included the BH-MCOs in the quality improvement process.

One commentator stated there are no requirements for the assessment or the ITP outcomes for an individual who does not have ASD or is not receiving ABA services.

Response:

Section 5240.61(a)(iii) (relating to quality improvement requirements) requires an assessment of the outcomes of services delivered and whether ITP goals have been

completed for all IBHS and is not limited to services to individuals with ASD or receiving ABA services.

The IRRC asked that the Department require the annual quality reports be posted on each IBHS agency's website and included in advertising literature.

Response:

The Department is requiring that reports be made available to the public upon request and that IBHS agencies provide written notification to individuals served by the agency that a copy of the report may be requested. These mechanisms will provide access to the reports. Also, IBHS agencies are not required to have a website or to use promotional materials.

Organizational structure

§ 5240.4 Organizational structure

Two commentators requested that the Department clarify when an IBHS agency must resubmit an organizational chart.

Response:

The organizational chart must be resubmitted to the Department if there are changes to the organization. This includes when a position is eliminated or other structural changes occur. An organizational chart does not need to be submitted each time a staff person is hired or leaves as long as the position continues to be occupied by a staff person.

One commentator stated it was not feasible for an IBHS agency to submit organizational changes to the Department within 10 days of a change and requested that this requirement be removed.

Response:

The Department has decided to allow an IBHS agency additional time to notify the Department of a change to its organizational structure. An IBHS agency will have 30 days to notify the Department of a change. This is consistent with Chapter 20 (relating to licensure or approval of facilities and agencies), which governs the licensing of agencies and also applies to IBHS agencies.

Administrative director of an IBHS agency

§ 5240.11 Staff requirements, § 5240.12 Staff qualifications, § 5240.81 Staff qualifications for ABA services

The Department has added a requirement that the administrative director's responsibilities include supervising staff who do not provide IBHS. The Department realized that it failed to address this responsibility in the rulemaking.

One commentator asked if one person could serve as both the administrative director and the clinical director and requested that if two people need to be hired, this be factored into the rates for IBHS.

Response:

There is no requirement that two individuals be hired. However, if only one individual serves in the role of administrative director and clinical director that individual needs to be able to perform all of the duties required for both positions and must meet the qualifications for both positions.

One commentator asked for how many entities can an administrative director be responsible. IRRC and another 12 commentators requested clarification about the duties of the administrative director that would require an administrative director to

dedicate a minimum of 7.5 hours each week to each IBHS agency the administrative director directs. Two commentators asked how agency is defined and if there is a maximum number of branches or satellites locations an IBHS agency can have. IRRC questioned why there is a need for the level of oversight included in the rulemaking by the administrative director.

Response:

The Department has revised the final-form rulemaking to remove the requirement that an administrative director dedicate 7.5 hours at each program the administrative director directs. The Department has also removed the provision allowing an administrative director to be responsible for more than one IBHS agency. The Department has determined that these requirements are not necessary because the rulemaking specifies the administrative directors' responsibilities and IBHS agencies should be allowed discretion to determine how best to ensure that an administrative director completes the administrative director's responsibilities.

IRRC and 14 commentators questioned why it is necessary for an administrative director to have a graduate degree.

Response:

The qualifications for an administrative director have been changed to require a bachelor's degree to better align the educational qualifications with the duties and activities for which the administrative director is responsible. Stakeholders indicated that an individual with a bachelor's degree could have the appropriate education and training needed to fulfill the responsibilities of the administrative director's position.

Clinical director of an IBHS agency

§ 5240.11 Staff requirements, § 5240.12 Staff qualifications, § 5240.81 Staff qualifications for ABA services

Three commentators questioned if the clinical director can carry a caseload.

Response:

The clinical director of an IBHS agency may provide services to a child, youth or young adult if the clinical director is qualified to provide the service. However, the provision of direct services cannot prevent the clinical director from completing the responsibilities of a clinical director described in § 5240.11(d)(1-5) (relating to staff requirements).

Two commentators questioned if a licensed social worker has the knowledge needed to be a clinical director of an IBHS agency that provides individual services or group services.

Response:

To be qualified to be a clinical director of an IBHS agency that provides individual services or group services a licensed social worker must also complete a graduate clinical or mental health direct service practicum. Stakeholders supported the inclusion of the practicum requirement because it ensures that licensed social workers have additional clinical training.

Eight commentators questioned why the qualifications for a clinical director of an IBHS agency that provides individual services or group services do not include individuals with a behavior specialist license.

Response:

The final-form rulemaking was revised to include that a clinical director of an IBHS agency that provides individual services or group services may be licensed as a behavior specialist if the individual also has a graduate degree that required a clinical or mental health direct service practicum. The Department included the practicum requirement to ensure that licensed behavior specialists have additional clinical training.

The Department has also revised the final-form rulemaking to include that a clinical director of an IBHS agency that provides individual services or group services may be licensed as a professional with a scope of practice that includes overseeing the provision of IBHS and have a graduate degree that required a clinical or mental health direct service practicum. The Department added this option because there may be new licenses created and individuals who obtain these licenses may have the expertise needed to be a clinical director of an IBHS agency that provides individual services or group services. Because the Department does not know what education will be required to obtain such a license, the Department included the requirement that the individual have a graduate degree that required a clinical or mental health direct service practicum to ensure that the individual has clinical training.

IRRC requested that the Department explain what is meant by the requirement in § 5240.12 (relating to staff qualifications) that a clinical director have a minimum of 1 year of full-time postgraduate experience in the provision of mental health direct service to children, youth or young adults. IRRC and one commentator questioned if experience includes working with children in a school, daycare or another child and adolescent service system program.

Response:

The clinical director's experience must include 1 year of working directly with a child, youth or young adult to provide mental health treatment after the clinical director received the clinical director's graduate degree. The experience can be in any setting as long as it involves the provision of mental health direct services that are included in a behavioral health treatment plan. This experience can be obtained while working with children in a school, daycare or another child and adolescent service system program.

One commentator questioned how an individual who is certified as a BCBA and is licensed as a behavior specialist has the training and experience to oversee mental health services which are provided through individual services, group services or EBT.

Response:

The final-form rulemaking was updated to include that a licensed behavior specialist who is a clinical director of an IBHS agency must have a graduate degree that required a clinical or mental health direct service practicum.

Three commentators questioned why the Department was relying on qualifications determined by the Behavior Analyst Certification Board, including the requirement that the clinical director of an IBHS agency that provides ABA services be certified as a BCBA.

Response:

Stakeholders indicated that it was important for the Department to consider the qualifications determined by the Behavior Analyst Certification Board because these qualifications are national standards.

IRRC asked the Department to explain the need and rationale for requiring monthly meetings between the clinical director and staff.

Response:

The Department has removed the requirement in the final-form rulemaking that a clinical director must meet with staff on a monthly basis and document the meeting because the rulemaking includes requirements that specifically address the supervision an individual who meets the qualifications of a clinical director must provide.

Qualification to provide IBHS

IRRC and four commentators stated that as a result of this rulemaking providers will be forced to use fewer independent contractors and hire more employees, which will result in increased costs and administrative responsibility.

Response:

The Department does not agree that as a result of this rulemaking providers will be forced to use fewer independent contractors and hire more employees because this rulemaking does not require an IBHS agency to change its current employment structure.

Two commentators asked if this rulemaking has made the behavior specialist license irrelevant

Response:

The behavior specialist license will continue to be relevant after this rulemaking is promulgated. The behavior specialist license is included in the qualifications to provide IBHS.

§ 5240.71 Staff qualifications for individual services

The Department revised the final-form rulemaking to clarify that to be qualified to provide behavior consultation services an individual who has a graduate degree in

psychology, social work, education or counseling must either have a minimum of 1 year of full-time experience in providing mental health direct services to children, youth or young adults or completed a clinical or mental health direct services practicum. The Department also revised the final-form rulemaking to clarify that if an individual has a graduate degree in a field related to psychology, social work, education or counseling, the individual must also have completed a clinical or mental health direct services practicum to be qualified to provide behavior consultation service. However, if an individual has a graduate degree in ABA, there are no additional requirements for the individual to be qualified to provide behavior consultation services. This is because a graduate degree in ABA cannot be obtained without 1 year of experience in providing mental health direct services.

Similarly, the Department revised the final-form rulemaking to clarify that to be qualified to provide mobile therapy services an individual must have a graduate degree in psychology, social work, or counseling; at least nine credits specific to clinical practice and must have either a minimum of 1 year of full-time experience in providing mental health direct services to children, youth or young adults or completed a clinical or mental health direct services practicum. The Department also clarified that to be qualified to provide mobile therapy services an individual who has a graduate degree in education or a field related to psychology, social work, education or counseling, must also have at least nine credits specifics to clinical practice and completed a clinical or mental health direct services practicum.

IRRC and two commentators requested that the requirement that individuals who provide individual services through behavior consultation services to children diagnosed

with ASD for the treatment of ASD meet the qualifications of an individual who provides behavior consultation-ABA services in § 5240.81(e) (relating to staff qualifications for ABA services) be removed from § 5240.71(b) (relating to staff qualifications for individual services).

Response:

The Department cannot remove this requirement because Act 62 of 2008 (40 P.S. § 764h) requires individuals who provide behavior specialist services to children, youth or young adults with ASD be licensed and § 5240.81 (relating to staff qualifications for ABA services) requires individuals who provide behavior consultation-ABA services to be licensed. This does not mean children, youth and young adults with ASD cannot receive services other than ABA or that children without ASD cannot receive ABA services. Rather it means that children, youth and young adults with ASD must receive services from staff who are licensed.

One commentator asked how many hours equal the 1 year of full-time experience in providing mental health direct services to children, youth or young adults that is required to be qualified to provide behavior consultation services or mobile therapy services.

Response:

Full-time experience includes time spent in both direct service provision and non-billable activities related to behavioral health services. IBHS agencies should review the employment activities of a potential candidate to determine if they have worked sufficient hours to constitute full-time experience.

One commentator stated that there are many references to certified registered nurse practitioners (CRNPs) needing a mental health certification in order to provide services, but this requirement was not included for CRNPs that provide individual services.

Response:

The Department did not include a requirement specific to CRNPs who provide behavior consultation services or mobile therapy services because CRNPs with mental health certifications will also satisfy the requirement that behavior consultation services and mobile therapy services be provided by individuals who have a graduate degree in a related field that includes a clinical or mental health direct services practicum.

One commentator requested that behavior specialist license be added to the licenses that an individual can hold to be qualified to provide mobile therapy services.

Response:

The final-form rulemaking was revised to include that an individual may be qualified to provide individual services through mobile therapy services if the individual is licensed as a behavior specialist and has a graduate degree that required a clinical or mental health direct service practicum. The Department included the practicum requirement to ensure that licensed behavior specialists that provide mobile therapy services have clinical training.

IRRC and six commentators requested clarification about the requirement that all individuals who provide BHT services obtain a certification. IRRC also requested that the Department explain the process whereby it would engage the Pennsylvania certification board to ensure that individuals who provide BHT services and are certified by the Pennsylvania certification board meet the Department's standards for training

and competency. In addition, the commentators requested information about how long it would take to complete the training needed for a certification. Another commentator asked if all individuals who provide BHT services would be required to obtain certification.

Response:

As a result of the comments received, additional stakeholder feedback and concerns that the certification requirement would result in there being an insufficient number of individuals who could provide the BHT service, the Department has decided to not require that all individuals who provide BHT services obtain certification within 18 months of being hired to provide BHT services or within 2 years of the promulgation of the rulemaking. Certification is now one of several options to qualify to deliver BHT services. Individuals can also be qualified to provide the BHT service if they have a high school diploma or equivalent and a certificate that indicates that they have completed a 40 hour training covering the RBT Task List or if they have a minimum of 2 years experience in the provision of behavioral health services. Individuals who provide BHT services will have until January 1, 2021, to meet one of these qualifications.

In addition, as a result of concerns about what the Pennsylvania certification board would require to obtain certification as a BHT, the Department has deleted the option that an individual obtain certification as a BHT from the Pennsylvania certification board to be qualified to provide BHT services and has removed all references to the Pennsylvania certification board from the final-form rulemaking.

Two commentators requested information about the cost of the training required to obtain certification that allows an individual to provide BHT service and how this training could be obtained.

Response:

How the training will be obtained will depend on the training entity chosen. Because there are several certifications that will be accepted, the cost and time to complete the certification program will vary.

One commentator asked what the Department meant when it stated that an individual who has an "other behavior analysis certification" can provide BHT services.

Response:

The Department has revised the requirement to be other "behavior health certification and behavior analysis certification" since a certification in behavioral health will provide an individual with the knowledge and training needed to provide individual services. The Department has included this requirement in the rulemaking because the Department does not know what other certifications will be developed after the promulgation of this rulemaking.

Three commentators suggested that the requirement that an individual with an associate's degree or at least 60 credits towards a bachelor's degree also have 1 year of full-time experience in providing direct mental health direct services be removed from the qualifications to provide BHT services because there will not be enough individuals who meet the qualifications to provide BHT services.

Response:

As a result of stakeholder feedback and to ensure that children, youth and young adults receive needed services from qualified individuals, the Department has revised the qualifications of individuals who can provide BHT services. As of January 1, 2021, individuals who have a certification as a BCaBA, RBT, BCAT or behavioral health certification or behavior analysis certification from an organization that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute; or a high school diploma or the equivalent of a high school diploma and have completed a 40 hour training covering the RBT Task List; or a minimum of 2 years of experience in the provision of behavioral health services may provide BHT services.

§ 5240.81 Staff qualifications for ABA services

The Department has revised and clarified the qualifications of the individuals who can provide behavior analytic services and behavior consultation-ABA services. To be qualified to provide ABA services through behavior analytic services an individual must be licensed as a psychologist, professional counselor, marriage and family therapist, clinical social worker, social worker, behavior specialist, certified registered nurse practitioner or a professional with a scope of practice that includes overseeing the provision of ABA services and have a certification as a BCBA or other graduate-level certification in behavior analysis. To be qualified to provide ABA services through behavior consultation-ABA services an individual must be licensed as a psychologist, professional counselor, marriage and family therapist, clinical social worker, social worker, behavior specialist, certified registered nurse practitioner or a professional with a scope of practice that includes overseeing the provision of ABA services and have a certification as a BCaBA or other undergraduate-level certification in behavior analysis,

a minimum of 1 year of full-time experience providing ABA services and a minimum of 12 credits in ABA or a minimum of 1 year of full-time experience providing ABA services under the supervision of a professional with a certification as a BCBA or other graduate-level certification and a minimum of 40 hours of training related to ABA. An individual who is licensed as a psychologist and has a minimum of 1 year of full-time experience providing ABA services and a minimum of 40 hours of training related to ABA is also qualified to provide ABA through behavior consultation-ABA services.

To ensure that all individuals have the knowledge needed to provide ABA services, the Department added a requirement that licensed individuals that have 1 year of full-time experience providing ABA services must also obtain a minimum of 40 hours of training related to ABA. As a result of the addition of this requirement, the Department has determined that it is no longer necessary to require an individual who provides behavior analytic services or behavior consultation-ABA services and is licensed as a behavior specialist to have at least 45 hours of training related to ABA before independently providing ABA services to a child, youth or young adult. Because an individual who is licensed as a behavior specialist can provide behavior analytic services or behavior consultation-ABA services if the individual has a certification as a BCBA or a BCaBA, a minimum of 12 credits in ABA or 40 hours of training related to ABA, such an individual would have training in ABA.

Thirteen commentators were concerned about licensed professionals who oversee or provide ABA services having to obtain an additional credential specific to the provision of ABA services. The commentators were especially concerned about the impact of this rulemaking on licensed psychologists.

Response:

The Department discussed the commentators' concerns about licensed professionals who oversee or deliver ABA services having to obtain additional credentials specific to the provision of ABA services with stakeholders. As a result of these discussions and the comments the Department received on this issue, the Department revised the final qualifications for a licensed psychologist to be a clinical director of an IBHS agency that provides ABA services and to provide behavior consultation-ABA services. Because licensed psychologist are required to obtain a doctoral level credential and have clinical training, the Department has determined that it is not necessary for a licensed psychologist to obtain additional credentials specific to ABA. However, the Department has included additional education, experience and training requirements for licensed psychologists who provide behavior consultation-ABA services in the final-form rulemaking.

IRRC and three commentators expressed concerns about allowing a clinical director 3 years to obtain a BCBA and stated that individuals could jump between agencies to avoid having to obtain certification.

Response:

The final-form rulemaking was updated to require that an individual meet the final qualifications to be a clinical director of an IBHS agency that provides ABA services by July 1, 2022. The Department chose July 1, 2022 to enable individuals who want to be clinical directors of IBHS agencies that provide ABA services sufficient time to complete the Behavior Analyst Certification Board approved course sequence, supervision requirements and take the certification exam. The Department also clarified that in

addition to obtaining a BCBA, an individual who is a clinical director of an IBHS agency that provides ABA services must also have a minimum of 2 years of experience in providing ABA services.

Eight commentators stated that the qualifications, training and supervision requirements for individuals that provide ABA services should align with the Behavior Analyst Certification Board's qualifications, training and supervision requirements. This includes following the national standards set by associations that work with the Behavior Analyst Certification Board, which include the Association of Professional Behavior Analysts as well as the International Academic Standards set by the Association for Behavior Analysis International and the practice standards set by the Behavior Analyst Certification Board.

Response:

In addition to consulting with stakeholders, the Department reviewed the Behavior Analyst Certification Board's standards and the requirements of its current BHRS system when it developed the qualifications, training and supervision requirements for individuals that provide ABA services. The Department modified requirements in an effort to align more closely with the Behavior Analyst Certification Board's requirements.

IRRC and four commentators requested that the Department clarify which individuals need to obtain certification as a BCBA to provide services.

Response:

An individual with a certification as a BCBA can be a clinical director of an IBHS agency that provides ABA services and provide behavior consultation-ABA services or

behavior analytic services. Behavior analytic services are the only service that must be provided by an individual who has a certification as a BCBA.

One commentator requested clarification about the term "behavior specialist analyst." The commentator stated that it appeared to be a combination of behavior analyst and behavior specialist, which are already recognized terms in the behavioral health field.

Response:

The Department is no longer using the term "behavior specialist analyst." The Department is instead using the term "behavior analytic services" and "behavior consultation-ABA services."

IRRC requested that the Department explain the process it intended to use to engage the Pennsylvania certification board to ensure that individuals who provide behavior consultation-ABA services or BHT-ABA services and are certified by the Pennsylvania certification board meet the Department's standards for training and competency.

Response:

As a result of concerns about what requirements the Pennsylvania certification board would impose for an individual to obtain certification, the Department has deleted the option that an individual obtain a certification from the Pennsylvania certification board to be qualified to provide behavior consultation-ABA services or BHT-ABA services.

§ 5240.91 Staff requirements and qualifications for group services

As part of simplifying the overall structure of IBHS, the Department has aligned the qualifications of the individuals who provide group services with the qualifications to provide individual services and ABA services. A graduate-level professional who provides group services must meet the qualifications to provide behavior consultation

services in § 5240.71(a) (relating to staff qualifications for individual services), the qualifications to provide mobile therapy services in § 5240.71(c), the qualifications to provide behavior analytic services in § 5240.81(d) (relating to staff qualifications for ABA services) or the qualifications to provide behavior consultation-ABA services in § 5240.81(e). Individuals who meet the qualifications to provide BHT services in § 5240.71(d) or the qualifications to provide BHT-ABA services in § 5240.81(g) may also provide group services.

The Department has also deleted the option that an IBHS agency that provides group services that include specialized therapies such as music, dance and movement, play or occupational therapies use staff that are supervised by a Nationally credentialed activities therapist. The Department has determined that Nationally credentialed activities therapists do no supervise individuals who provide specialized therapies. However, the Department has added as an option that an individual providing a specialized therapy be licensed in this Commonwealth in the specific therapy. This change was made because occupational therapists are licensed in Pennsylvania and other relevant licenses may be developed.

One commentator asked that the Department define "mental health professional" because it is a term the Department uses in other programs and for other license types.

Response:

The term "mental health professional" has been removed from the final-form rulemaking and replaced with "graduate-level professional."

Three commentators questioned the difference between a mental health worker and an individual who can provide BHT services and asked why there is a difference in the

services these individuals can provide. The commentators indicated that they were confused why the Department made a distinction between individuals who are mental health workers and individuals who can provide BHT services. Five commentators suggested adding a definition of "mental health worker" to clarify how it is different from an individual who provides BHT services.

Response:

Because of the distinction between what services an individual who meets the qualifications to provide BHT services can provide and what services a mental health worker can provide caused confusion and created a discrepancy in the rulemaking between the qualifications of the individuals who could perform individual services and group services, the Department has deleted the requirement that a mental health worker provide group services.

Supervision and training requirements

§ 5240.13. Staff training plan, § 5240.72 Supervision of staff who provide individual services, § 5240.73 Training requirements for staff who provide individual services, § 5240.82 Supervision of staff who provide ABA services, § 5240.83 Training requirements for staff who provide ABA services, § 5240.92 Supervision of staff who provide group services, § 5240.93 Training requirements for staff who provide group services

IRRC requested that the Department explain how the supervisory standards included in the rulemaking ensure the protection of children, youth and young adults who receive IBHS. IRRC also requested that the Department explain the need for and reasonableness of the level of supervision required for staff. In addition, stakeholders

indicated that they were concerned about the supervision standards in the proposed rulemaking.

Response

The supervision requirements protect children, youth and young adults who receive IBHS because they require that all staff receive supervision. Supervision provides oversight of the manner in which services are being delivered and allows staff who are delivering services to receive support and guidance. Previously, there were no supervision requirements for graduate-level staff.

The Department discussed with stakeholders the concerns about the amount of supervision required for staff who provide individual services. While stakeholders agree that there is a need for supervision, they also generally agreed that the amount of supervision time included in the proposed rulemaking should be reduced. As a result, the Department has decreased in the final-form rulemaking the frequency of required face-to-face supervision and onsite supervision.

Three commentators expressed concern about the cost of the training and supervision requirements for providers who use independent contractors to provide services.

Response:

The Department does not understand why agencies who use independent contractors will have costs that are different than agencies that do not use independent contractors. All agencies must train and supervise staff who provide services.

IRRC requested clarification on the difference between supervision, face-to-face sessions and direct observation.

Response:

The Department revised the final-form rulemaking to clarify what supervision includes and the formats in which it may be delivered. Supervision includes the oversight of the clinical services provided by a staff person to each child, youth or young adult. This includes review of the interventions being implemented; the child's, youth's or young adult's progress towards the goals of the ITP; consideration of adjustments needed to the ITP and the staff person's skills in implementing the interventions in the ITP.

Face-to-face supervision occurs when the individual being supervised meets with the individual's supervisor in-person or through a secure means that enables the individuals to observe each other. Direct observation occurs when the supervisor observes staff during the provision of services.

IRRC and 12 commentators asked how training is approved by the Department, the time frame for obtaining approval and how the Department will notify an IBHS agency of its decision to approve or not approve a training.

Response:

The Department will develop and disseminate the process it will be using to approve IBHS training.

One commentator inquired if college coursework can be used to satisfy the initial training requirements. The commentator asked if there is a limit on how long ago the coursework was completed and if coursework is counted by credit hour or course hour.

Response:

There is no limit on how long ago a college course was completed for it to be used to satisfy a training requirement as long as the individual can verify the content of the course (e.g. syllabus, course description). Hours are counted by credit hours.

The Department has also revised the final-form rulemaking to clarify that hours of continuing training required to maintain certification or licensure may count towards the training requirements included in the final-form rulemaking.

Four commentators requested that the Department clarify the difference between clinical supervision and administrative supervision.

Response:

The Department has revised the supervision sections of the final-form rulemaking to clarify what clinical supervision should include. The Department has not imposed any specific requirements on administrative supervision. Administrative supervision should address the operations of the IBHS agency.

One commentator asked what is meant by the IBHS agency must ensure that all staff complete training requirements.

Response:

An IBHS agency must be able to demonstrate that its staff have completed the required trainings.

One commentator asked which trainings are allowed to be provided by an IBHS agency.

Response:

An IBHS agency can provide training on any topic that is required to be addressed by this rulemaking.

One commentator expressed concern about not knowing the quality of another provider's training and how an IBHS agency can obtain documentation from another agency that indicates that a staff person has already undergone training.

Response:

An agency may accept training completed by another IBHS agency, but it is not required to accept it. The rulemaking allows for a number of different certification options which will enable individuals to receive standardized training. In addition, the Department must approve independent trainings, which will provide IBHS agencies with assurances about the quality of the training.

IRRC and one commentator suggested that "date of hire" be removed from the requirement that staff training plans be updated annually based on the staff's date of hire because this would ease some of the burden imposed by the requirement for annual staff training plans.

Response:

The Department has removed "based on the date of hire" from § 5240.13(a)(1)(i) (relating to staff training plan).

IRRC and one commentator asserted that the requirement in § 5240.13(e)(6) (relating to staff training plan) to keep a copy of written materials that were used during a training is burdensome, costly and does not provide a benefit. IRRC requested that the Department explain the need for and reasonableness of this requirement.

Response:

The Department does not agree that there is no benefit to requiring IBHS agencies to keep a copy of the materials that were used during a training. The materials provide information on what staff was trained on, which allows the Department to verify that staff were trained in accordance with this rulemaking and that the training was consistent with best practices. The Department has revised the final-form rulemaking to allow

IBHS agencies to keep electronic copies of the trainings, which will reduce the costs and burden of retaining copies of the training materials.

IRRC pointed out that the Department included both references to "audio and video transmission" and "audio or video medium" in the rulemaking and requested that the Department clarify how supervision should be conducted and that it use consistent terms throughout the rulemaking.

Response:

The Department has revised the rulemaking to use consistent terms. Supervision may be provided though secure audio and video transmission.

IRRC questioned the role of an IBHS supervisor.

Response:

The final-form rulemaking does not include references to an "IBHS supervisor." The Department has revised the rulemaking to identify the qualifications required for an individual to supervise another staff person. An individual who meets the qualifications of a clinical director may provide supervision to individuals who provide behavior consultation services and mobile therapy services. An individual who meets the qualification of a clinical director or is qualified to provide behavior consultation services or mobile therapy services may provide supervision to individuals who provide BHT services. Because the Department is requiring that an individual who meets the qualifications of a clinical director provide supervision to individuals who provide behavior consultation services and mobile therapy services and not an IBHS supervisor, the Department has deleted the requirement in § 5240.11 (relating to staff qualifications)

that a clinical director provide 1 hour of supervision to all staff that supervise other staff at least two times a month.

IRRC and 11 commentators requested that the Department explain why it is reasonable to limit the number of staff who can be supervised to nine full-time equivalent staff who provide BHT services. IRRC also requested that the Department explain why there is no limit on the number of other staff who can be supervised by one individual.

Response:

The Department discussed the number of individuals that can be supervised by one person during the meetings with stakeholders. As a result of feedback received from stakeholders, this section was revised to allow an individual to supervise a maximum of 12 full-time equivalent staff who provide individual services, but only nine of the full-time equivalent staff can provide BHT services. The Department also aligned the number of staff that can receive group supervision with the number of individuals that may be supervised by one person.

These changes were made to allow individuals who provide behavior consultation services or mobile therapy services to be supervised by the same person who is supervising the individual who is providing BHT services to a child, youth or young adult. The Department has limited the total number of staff that an individual can supervise to 12 full-time equivalent staff to ensure that individuals providing IBHS receive adequate clinical oversight. The Department limited the number of individuals providing BHT services that can be supervised by one individual to nine full-time equivalent staff because this is consistent with the current limitation on the number of

individuals providing TSS services that can be supervised by one individual and individuals that provide BHT services usually provide more hours of service to children, youth and young adults than individuals who provide behavior consultation services or mobile therapy services and individuals who provide BHT services do not have as much education as individuals who provide behavior consultation services and mobile therapy services.

One commentator questioned if assessment and assistance would still be a requirement for individuals providing BHT services and if assessment and assistance hours would count towards the 30 hours of training required before an individual can provide BHT services to a child, youth or young adult.

Response:

The rulemaking replaces the requirements in bulletins issued by the Department. Assessment and assistance is now onsite supervision. The rulemaking requires that individuals who provide BHT services must receive 6 hours of onsite supervision during the provision of services prior to providing individual services independently. An individual providing BHT services must receive 30 hours of Department approved training required before the individual can independently provide BHT services to a child, youth or young adult.

One commentator asked if a provider's employee orientation can be counted towards satisfying the initial training requirements for an individual that provides BHT services and what other training resources are available.

Response:

Time spent during employee orientation on topics that must be covered as a result of the initial training requirements may count towards the 30 hours of training required before an individual can provide individual services to a child, youth or young adult. While the Department does not endorse specific training resources, training resources include trainings provided by the Department's Bureau of Autism Services, Pennsylvania Training and Technical Assistance Network and the Child Welfare Resource Center.

One commentator requested that the training requirements for individuals who provide behavior consultation services to children with ASD be clarified.

Response:

Individuals who provide behavior consultation services must complete at least 16 hours of Department approved training annually that is related to the individual's specific job functions and is in accordance with the individual training plan. This requirement applies to all individuals who provide behavior consultation services regardless of the behavioral health diagnosis of the child, youth or young adult the individual serves.

One legislator and 22 commentators expressed concern that supervision standards were being lowered because individuals who meet the qualifications to provide assistant behavior consultation-ABA services can supervise individuals who provide BHT-ABA services.

Response:

The Department has reviewed these comments and determined that there was a misunderstanding about the qualifications of individuals who can supervise individuals who provide BHT-ABA services. Only individuals who provide assistant behavior

consultation-ABA services and have a BCaBA can supervise individuals who provide BHT-ABA services. By July 1, 2022 all individuals who provide assistant behavior consultation-ABA services will be supervised by individuals who are certified as BCBAs or by licensed psychologists who have experience in providing clinical oversight of ABA programs and training related to ABA or licensed psychologists with graduate degrees or graduate certificates in ABA. The Department clarified the misunderstanding during discussions with stakeholders and stakeholders have not expressed further concern about individuals who have a BCaBA and meet the qualifications to provide assistant behavior consultation-ABA services supervising individuals that provide BHT-ABA services.

One commentator asked if someone other than the clinical director can provide supervision to staff who provide group services.

Response:

Section 5240.92 (relating to supervision of staff who provide group services) has been revised and no longer requires the clinical director to provide supervision to the graduate-level professional. Supervision can now be provided by anyone who meets the qualifications of a clinical director of an IBHS agency.

In addition, as a result of confusion about the different training and supervision requirements, the Department has aligned the supervision and training requirements for group services with the supervision and training requirements for other IBHS.

Provision of individual services

§ 5240.75 Individual services provision

IRRC and 14 commentators requested that the Department clarify the therapeutic activities and interventions that can be delivered through individual services. Five of these commentators specifically asked who can develop the ITP. IRRC and six commentators stated that individuals who provide BHT services should not be allowed to make referrals. In addition, IRRC asked why consultation with parents, teachers and other caregivers was not included as part of individual services and one commentator asserted that consultation should be expanded to include all necessary treatment team members.

Response:

As a result of the comments received and feedback obtained from stakeholders, the Department has revised § 5240.75 (relating to individual services provision). Section 5240.75 no longer lists the specific individual services a person can provide, but instead includes an overview of activities that may be delivered through behavior consultation services, mobile therapy services and BHT services.

The Department agrees that consultation should be expanded to include all necessary treatment team members and has removed the requirement that individuals providing behavior consultation services consult only with mobile therapists and BHTs about behavioral management protocols. The Department has revised the final-form rulemaking to provide that behavior consultation services consist of clinical direction of individual services, development and revision of the ITP, oversight of the implementation of the ITP and consultation with the treatment team on the ITP.

Mobile therapy services consist of individual therapy, family therapy, development and revision of the ITP, assistance with crisis stabilization and assistance with addressing problems the child, youth or young adult has encountered.

The Department also agrees that individuals who provide BHT services should not be allowed to make referrals. The Department has simplified its description of BHT services in the final-form rulemaking. The final-form rulemaking states that BHT services consist of implementing the ITP. Accordingly, the Department has deleted the requirement in the final-form rulemaking that prohibits an individual providing BHT services from developing or revising the ITP goals, objectives or interventions.

In addition, the Department has revised the final-form rulemaking to clarify that individual services, if medically necessary, can be provided by more than one individual at a time.

ABA services

§ 5240.87 ABA services provision

IRRC and 21 commentators requested that the Department clarify the therapeutic activities and interventions that can be provided through behavior analytic service, behavior consultation-ABA services, assistant behavior consultation-ABA services and BHT-ABA services. Four commentators requested that the Department clarify if therapeutic activities and interventions include training parents and caregivers on implementing the ITP. IRRC and three commentators suggested including language that indicates that ABA services can include interventions that target activities of daily living and skill development.

Response:

The Department has revised the final-form rulemaking to no longer include a prescriptive list of therapeutic activities, but instead include an overview of the ABA services that may be delivered through behavior analytic services, behavior consultation-ABA services, assistant behavior consultation–ABA services and BHT-ABA services. Behavior analytic services and behavior consultation–ABA services consist of clinical direction of ABA services, development and revision of the ITP, oversight of the implementation of the ITP and consultation with the child's, youth's or young adult's treatment team on the ITP. Additionally, behavior analytic services include conducting a functional analysis. Assistant behavior consultation-ABA services consist of assisting an individual who provides behavior analytic services or behavior consultation-ABA services and providing face-to-face behavioral interventions. BHT-ABA services consist of implementing the child's, youth's or young adult's ITP.

ABA services can be used to develop skills, including skills related to activities of daily living. An ITP may identify interventions that can be used to assist a child, youth or young adult with achieving or maintaining the skills needed for maximum functional capacity in performing activities of daily living.

Fifteen commentators expressed that they were concerned that children with ASD would only be able to receive ABA services and that ABA services would only be available for children, youth and young adults with an ASD diagnosis.

Response:

Children, youth and young adults diagnosed with ASD can also receive individual services and group services and are not limited to ABA services. Likewise, ABA

services can be provided to children, youth and young adults who do not have an ASD diagnosis.

Currently providers are required to attest to having the skills and knowledge to provide ABA services. One commentator questioned whether the attestation process is necessary since the rulemaking clearly stipulates training requirements and credentials.

Response:

The attestation process will no longer be used upon promulgation of this rulemaking.

One commentator asked if monthly reporting on the capacity of providers to provide ABA services will continue to be required after promulgation of this rulemaking.

Response:

Reporting on capacity to provide ABA services will continue to be required after this rulemaking is promulgated. The Department will provide guidance to the BH-MCOs.

Group services

§ 5240.97 Group services provision

As it has done for other services, the Department revised § 5240.97 (relating to group services provision) to no longer list the specific services a person can provide, but instead includes an overview of activities that may be delivered through group services.

One commentator asked what community integration activities are allowed as part of group services.

Response:

Community integration activities that enable children, youth and young adults to use skills learned through group services in the natural environment or address a specific goal are allowed as part of group services.

One commentator requested that the Department define "individual interventions" to clarify what individual interventions may be billed as part of group services.

Response:

The Department does not believe that a definition of "individual interventions" is necessary to clarify what individual interventions may be billed as part of group services. The rulemaking states that in order for an individual intervention to be billed as part of group services the individual intervention must address identified therapeutic needs for the child, youth or young adult to function in the home, school or community.

Two commentators were in favor of the graduate-level professional being able to provide consultation with the treatment team as part of group services.

Response:

Section 5240.97(a) (relating to group services provision) has been revised to include consultation with the child's, youth's or young adult's treatment team on the ITP as a service a graduate-level professional can provide.

One commentator requested that the Department add a requirement that a graduate-level professional must be present during the provision of group services.

Response:

The Department agrees and has added the requirement that a graduate-level professional be present during the provision of group services.

Two commentators asked what ratios will be required for group services.

Response:

Given the wide range of approaches, needs and programming occurring within group services the Department will not be requiring a specific staff ratio. Staffing ratios must be included in an IBHS agency's approved service description.

One commentator asked if there is a restriction on the number of groups that can occur in one day.

Response:

There is no restriction on the number of groups that can occur in one day; however, the number of groups that occur in one day must take into account the needs, age and functional abilities of the children, youth and young adults served as well as the staffing levels, hour of operation and size and space of the facility where services are being provided. An IBHS agency must include the number of groups and explain why this is an appropriate number in its service description.

IRRC asked if there is a maximum number of children, youth or young adults who can receive group services at a particular time and requested that if there is a maximum number it be specified in the final-form rulemaking.

Response:

There is no maximum number of children, youth or young adults who can receive group services at one time. The final-form rulemaking requires an IBHS agency that provides group services to include in its service description the staffing ratio for group services and the maximum number of children, youth or young adults who will be served at the same time through group services at each community setting or community like setting.

One commentator requested that the Department describe how individual, group and family therapy can occur in group services.

Response:

There is no one way for an IBHS agency to deliver group services that include individual, group and family therapy. It is up to the IBHS agency to decide if all three therapies should be part of their program and how the agency will deliver each therapy.

Five commentators questioned how group services will be billed, including if group services should be billed by number of units, what is a billable activity, if there will be a restriction on the number of group hours that can be billed in a day, if rates will support the rent for the location where services are provided and if there is a separate rate for different types of psychotherapy.

Response:

The Department plans to issue billing guidance that addresses group services.

Seven commentators requested that IBHS agencies be allowed to provide ABA when providing group services.

Response:

The Department agrees that IBHS agencies can provide ABA through group services and has revised the definition of group services to clarify that ABA services may be provided during the provision of group services.

Group services in school

§ 5240.98 Requirements for group services in school settings

The Department has changed the requirement in § 5240.98(2) (relating to requirements for group services in school settings) for a quarterly meeting between

IBHS agency and school staff to discuss the student's behavioral health services and progress related to school performance to at least every 6 months to align this time frame with the time frame for updates to the ITP. ITPs for group services must be updated at least every 6 months. The Department has also changed the requirement in § 5240.98(1)(iv) for a quarterly meeting between IBHS agency staff and school administration to review performance, collaboration issues and the written agreement to instead require that there be a meeting every 6 months so that only one meeting is needed between IBHS agency staff and school administration every 6 months. At this meeting IBHS agency and school staff can address behavioral health services a student is receiving and the student's progress as well as review the performance of the group services and collaborate on issues.

One commentator asked if group services in school settings will replace outpatient satellite clinics that are located in schools.

Response:

Outpatient services can continue to be provided at satellite sites in schools.

One commentator expressed concern that group services in the school setting will duplicate services schools are providing.

Response:

To prevent group services from being duplicative of services schools are providing the Department has included a number of provisions in the rulemaking that are intended to foster communication between the school and the IBHS agency and awareness of the services the IBHS agency is providing. These include a requirement for a written agreement with the school that provides for identification of space and equipment

allocated for use by IBHS agency staff, describes how the school and IBHS agency staff will collaborate during the provision of group services in the school and identifies an authorized representative for the school.

Two commentators asked who can be an authorized representative for a school.

Response:

A school is responsible for determining its authorized representative.

Two commentators asked the Department to provide an example of the written agreement needed between the IBHS agency and the school.

Response:

The Department expects that the written agreements will vary greatly because they must be specific to the program the IBHS agency is providing, and therefore will not be providing an example.

One commentator asked what the requirement in § 5240.98(a)(1)(iii) (relating to requests for group services in school settings) for "assurances of the collaborative relationship between school staff and IBHS agency staff" means. IRRC requested that the Department revise § 5240.98(a)(1)(iii) because "assurances" is not a regulatory term.

Response:

The Department has revised § 5240.98(a)(1)(iii). Section § 5240.98(a)(1)(iii) requires that the written agreement with the school include a description of how the school and IBHS agency staff will collaborate during the provision of group services in the school.

Two commentators asked the Department to clarify expectations when school is not in session.

Response

In § 5240.98(5)(i) (relating to requirements for group services in school settings) the Department requires that the ITP for every child, youth or young adult who receives group services include how continuity of services when school is not in session will be addressed. As a result, the ITP must include what services or supports are needed if school is not in session.

Evidence-Based Therapy

§ 1155.35 Payment conditions for EBT delivered through individual services, ABA services or group services, § 5240.103 Requirements for EBT delivered through individual services, ABA services or group services

The Department has moved the provisions on EBT in the rulemaking to follow the discussion of the other services because individual services, ABA services and group services can be provided through EBT.

IRRC and one commentator stated that many EBTs do not have certification or licensure from a National certification organization or entity and cannot comply with § 1155.35(a)(7) (relating to payment conditions for EBT delivered through individual services, ABA services or group services). IRRC and the commentator also pointed out that while § 1135.35(a)(7) requires an IBHS agency to have a current certification or licensure from the National certification organization or entity that developed or owns the EBT, § 5240.103(a) (relating to requirements for EBT delivered through individual services, ABA services or group services) specifies that a certification or license is only necessary if it is required to provide the EBT.

Response:

Each EBT has its own requirements for licensure, certification or training for an individual or program to be recognized as being able to provide the EBT. The Department is requiring an IBHS agency that provides an EBT to have a current certification or licensure from the National certification organization or entity that developed or owns the EBT. The Department has revised the language in the final-form rulemaking so that the requirements in § 1135.35(a)(7) (relating to payment conditions for EBT delivered through individual services, ABA services or group services) and § 5240.103(a) (relating to requirements for EBT delivered through individual services, ABA services or group services) are consistent.

Two commentators questioned if providers who currently provide an EBT will be required to comply with this rulemaking (i.e. providers that offer Trauma Focused-Cognitive Behavioral Therapy, Dialectical Behavior Therapy through an outpatient program, Multisystemic Therapy, Functional Family Therapy).

Response:

Not all providers of an EBT will need to comply with this rulemaking. Only providers of an EBT delivered through IBHS need to comply with this rulemaking.

Two commentators recommended that if ABA is not appropriate for a child, youth or young adult, the Department should issue guidance around which EBT may be appropriate.

Response

The Department will not be issuing guidance regarding the most appropriate use of an EBT because each EBT outlines its target population, including admissions criteria, for the service.

Six commentators requested clarification as to why the section of the rulemaking that addresses EBT does not include the same level of details as other sections of the rulemaking. The commentators requested that the Department clarify the overall scope of services and program standards for EBT such as supervision and training requirements and staff qualifications. IRRC also requested that the Department clarify the standards IBHS agencies that provide EBTs must adhere to when the rulemaking is silent on issues such as supervision, minimum qualifications, admissions or discharge criteria.

Response:

IBHS agencies should comply with the EBT's requirements for supervision, minimum qualifications, admissions and discharge criteria. If the EBT does not provide guidance on an issue, the IBHS agency should adhere to the requirements in the rulemaking that address the specific service the provider is delivering (individual services, ABA services, group services).

IRRC and two commentators questioned if an EBT can be modified to meet a child's, youth's or young adult's needs.

Response:

An EBT should not be modified unless allowed within the parameters of the EBT.

Two commentators asked if providers will be able to bill for all services included in an EBT.

Response:

IBHS agencies cannot bill for services included in the EBT that are not reimbursable through the MA Program.

One commentator requested information on how an agency should obtain a license or certification for the EBT it wants to provide.

Response:

Each entity that developed or owns an EBT has its own process for licensing or certifying a program that provides an EBT or an individual who provides an EBT.

Location of services

Two commentators stated that it is in unclear if the Department will allow services other than group services to be delivered in the provider's office when clinically indicated. One of these commentators suggested that this be clarified in the definition section of the rulemaking and the other commentator indicated that families have requested that their child receive services in a provider's office or clinic. Another commentator suggested that for purposes of the provision of ABA services "community" should be defined to include a provider's office or a clinic because some aspects of ABA services may best be provided in an office setting and then transferred to the home, school, or other setting. The commentator explained that outpatient mental health therapy and virtually all other therapies, including physical therapy, occupational therapy and speech therapy, are permitted to be provided in clinics and provider's offices. The commentator believes that there is no reason to treat ABA services differently. The commentator also stated that if providing ABA services in an office or clinic setting is not allowed under the IBHS rulemaking, then the Department should allow providers to provide office and clinic services through other means. As a result of the concerns about where site-based services can be provided, IRRC also requested that the Department define "community" for purposes of ABA services.

Response:

The final-form rulemaking does not prevent an entity from providing services in an office setting that is not community like; however, these services cannot be billed to MA as IBHS.

Waivers

§ 5240.111 Waivers

Two commentators support the continuation of exceptions written around specific diagnostic categories and specific individuals. One commentator stated that the waiver process should be consistent with current Department bulletins. The commentator also recommended time frames.

Response:

The Department established the ability to seek a waiver of regulatory requirements in the final-form rulemaking. The Department will issue a bulletin that sets forth the procedures for seeking a waiver, including the timelines.

One commentator asked whether existing program exceptions that do not meet the criteria in the proposed rulemaking will fall under a waiver exception.

Response:

Services previously approved through a program exception would generally fall under the final-form regulations and would be expected to meet the standards established in this rulemaking. If there is an exception needed, the waiver process can be followed.

The Department also received comments about the Child Protective Services Law, 23 Pa.C.S. §§ 6301—6386. The Child Protective Service Law is beyond the scope of this

rulemaking. Information about child abuse certifications and criminal history checks can be found at http://keepkidssafe.pa.gov/.

In addition to the major changes discussed previously, the Department made several changes in preparation of the final-form including revising language to enhance clarity and to conform to the changes previously discussed.

Regulatory Review Act

Under § 5.1(a) of the Regulatory Review Act (71 P.S. § 745.5(a)), on JUL 11 2019 the Department submitted a copy of these regulations to IRRC and to the Chairpersons of the House Human Services Committee, House Health Committee and the Senate Health and Human Services Committee. In compliance with the Regulatory Review Act, the Department also provided the Committees and IRRC with copies of all public comments received, as well as other documentation.

In preparing the final-form regulations, the Department reviewed and considered comments from the Committees, the IRRC and the public.

In accordance with § 5.1(j.1) and (j.2) of the Regulatory review Act, these regulations were [deemed] approved by the Committees on _____ (insert date). The IRRC met on _____ (insert date) and approved the regulations.

In addition to submitting the final-form rulemaking, the Department has provided the IRRC and the Committees with a copy of the Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

Order

The Department finds:

(a) The public notice of intention to adopt the administrative regulations by this Order has been given pursuant to §§ 201 and 202 of the Commonwealth Documents Law (45 P. S. §§ 1201 and 1202) and the regulations at 1 Pa. Code §§ 7.1 and 7.2.

(b) That the adoption of these regulations in the manner provided by this Order is necessary and appropriate for the administration and enforcement of the Human Services Code.

The Department, acting pursuant to §§ 201(2) and 1021 of the Human Services Code (62 P.S. §§ 201(2) and 1021) and § 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)), orders:

(a) The regulations of the Department is adopted to read as set forth in Annex A of this Order.

(b) The Secretary of the Department shall submit this Order and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this Order and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon publication. Providers will be required to comply with this rulemaking 90 calendar days after publication in the *Pennsylvania Bulletin*.