Summary Bullet Points 150309 on SF 1356 Article 2 Section 5 02/24/15 DHS Proposed Amendments to CTSS Law

(see below for list of specific details, grouped into green yellow red)

CTSS is stated to be a "flexible" package of mental health services. However, CTSS regulations have been problematic because many of the features of the CTSS excessive micro-management are in conflict with evidence-based ABA. These conflicts reduce access to services, put children at risk of harm, and reduce cost-effectiveness. As a result ABA providers have been subject to excessive audit risk.

The micromanagement is counterproductive, because it is extremely expensive for the DHS to enforce, and it doesn't even enforce quality treatment. Instead, all it does is put providers at undue audit risk. The undue risks are inflexible deadline requirements, and paperwork requirements.

Instead of trying to ineffectively enforce the many requirements, optimized reimbursement rates would serve to eliminate disincentives for delivering the best services. Then increased technical assistance with disadvantaged providers would help them reach optimum functioning. Proper payment rules can prevent wasted spending.

For paperwork (which is unreimbursed), there are four written plans required: ITP, IBP, Crisis Plan, and Supervision Plan. Following these, the progress note requirements are tangential to objective ABA data logging and analysis, forcing the providers into maintaining duplicate record keeping systems, which again are unreimbursed.

For staffing, the DHS has substituted a requirement that staff have a magical year of experience prior to being hired, instead of reimbursing the more functional (and evidence-based) ongoing training of direct line therapists. The ongoing training is the only way that staff can individualize to the unique needs of each child, and not repeat the pitfalls of bad ABA.

In an ABA approach, staff would be reimbursed for overlapping functional training activities each week. In CTSS that is considered illegal, without any evidence to support the ban.

Further, the most difficult children require two staff present in order to ensure their safety as behavioral procedures are implemented. However this cost is not reimbursed, leading us to fail with the children who will be most expensive throughout their lives.

The CTSS system requires the professional psychologist to serve the regular oversight activities, which simply reduces access. There are less than ten behavioral psychologists in Minnesota. Instead the field of ABA has developed a system of certifying master's level behavior analysts who can perform this role more effectively because they can be in the home and center each week, become fully conversant with each child's individual needs, and train and manage each child's program to expedite completion of their therapy.

The ABA system also calls for assistant behavior analysts who can extend the reach of the behavior analyst, and in effect be in training to become behavior analysts themselves. The BACB has a complete system for ensuring the quality of this division of labor.

The ABA system directly trains the parents and teachers as targets of the intervention, because they will sustain the treatment throughout the 168 hour week and after the service is done. Yet the CTSS rules make this very difficult or simply noncovered.

Finally the ABA system has a built in evidence-based system of outcome measurement. However, the CTSS rules don't cover the extensive assessment and analysis system, so many providers fail to conduct it. Proper payment will ensure that all systems are implemented.

In summary, if there were a way to write into statute that the CTSS program would work to support the guidelines published by the BACB, then the service would be functional and cost-effective.

Some of the amendments in this bill are improvements. Some of the amendments are confusing. Some are problematic. And some of the problems have not yet been addressed.

CTSS amendments in this bill that are improvements.

- "Telemedicine" has been added to the definition of "direct service."
- "Treatment plan development" and "recording individual outcomes" has been added to "direct service."
- It is clarified that the ITP may be developed by an MHP under the supervision of a professional.
- It is clarified that direct work with the family is a direct service and eliminates the "child present" requirements that currently interfere with parent training, case management, and consultation to other providers.
- "Address Intellectual processing deficits" are included in the definition of rehabilitation.
- The requirement of a five-axis diagnosis is removed, as compatible with the new DSM-5.
- Synchronizes CTSS with the new autism EPSDT program as far as reporting progress data is concerned.
- Requires individual treatment outcome measurement.
- Clarifies that parents are to be part of treatment planning.
- Allows the parent signatures to be collected later, when practical.
- The date of discontinuation and the reason should now be documented.

CTSS amendments that will cause problems.

- Requires having a documented back-up mental health professional.
- Requires a written procedure for external assessments (which can not be guaranteed due to severe shortages).
- Requires a deadline for incorporating baseline data into an external assessment.

CTSS amendments that need clarification.

- The incorporation of the "Clinical Trainee" could be used as a substitute for the BCBA, and allow an MHP to conduct various supervised professional activities, though it does come with a large amount of paperwork requirements. The reimbursement rate would have to be clarified to ensure that it is cost effective.
- Increased requirements for "Crisis Assistance" planning and documentation may be onerous. It is not clear that this kind of paperwork and case management will be reimbursed.
- "Direct service time" does not include work before and after providing direct services, is confusing in light of the addition of "Treatment plan development" and "recording individual outcomes" to "direct service."
- It appears that "consultation with others" "preparing reports" and "clinical supervision" are now reimbursable.
- The "allied field" item seems to have been added as a definition of a mental health professional. This would open the door for BCBAs to serve all of the necessary functions and eliminate many problems.
- Psychotherapy has received increased emphasis, with some paperwork requirements that conflict with ABA, but is identified as treatment by "psychological means," which includes ABA. So if the BCBA is included as a professional, then it will enable the provider to meet the requirements for psychotherapy, despite the increased emphasis on treating the "underlying causes" of the disorder – an assertion which is not evidence-based. There is a provision to declare a shortage here, but it must be done in writing in the child's ITP. However the ITP must now specify how the skills training is integrated with the psychotherapy in order to "address the underlying condition." This is not evidence based.
- Crisis services are allowed, which could help reduce the micromanagement of the ITP and progress notes to always have a current goal or objective in place.
- All staff training, planning requirements and monitoring functions should be reimbursed.
- Increases the requirements for the 90-day ITP review. If the BCBA can conduct these, then the requirements are not as onerous and risky to the audit.
- The "Therapeutic Preschool" features have been eliminated in favor of "day treatment." Is this a problem? The attendance and availability requirements have been increased. Increased flexibility has also been added.
- The requirement for direct on-site observation by the professional may reduce rural access, unless telemedicine is an appropriate feature.

CTSS features that are not addressed but should be amended.

- Clinical direction should be included as a direct service, and be reimbursed appropriately to eliminate the disincentive to ensure program continuity.
- The MHBA's require a second, duplicated set of daily documentation – both an Individualized Behavior Plan and an Individualized Treatment Plan. This has been accompanied by the requirement for distinct data collection and

progress notes. This should just be part of the ITP.

- Wherever the progress note is required, it should be modified to allow for ABA-standard data logging, which is more objective.
- The MHBA's can only maintain and generalize but not teach new skills. Not only does this conflict with consistent team and parent implementation, but it sets up a scheduling requirement that is impossible to meet, thus causing audit gotchas.
- The MHBA's can not implement behavior reduction plans, including physical escort, physical holding, or time out. Our position is that sufficient behavioral training and management enables the MHBA to implement these procedures along with the parent, and so the child is safer, and the service is more accessible. In addition the case management and documentation requirements should be reimbursed.
  This would result in inconsistent treatment and harm the children.
- The MHP should not be required to have 2,000 hours. The ABA program integrates competency-based training into the service model. This only reduces access.
- The requirement for MHBA's to attend DHS training on family relationships should be flexible to allow providers to deliver their own training, which is more individualized to the family.
- Current CTSS Reimbursement Rate Disincentive:
  The current rates are structured so there is a disincentive to provide the required staff training and planning activities. For example, The MHP would bill at $63.96 per hour of direct services. But when they supervise the MHBA, they can only bill at $34.52 an hour. In combination with the MHBA's reimbursement, this is a total of $65.48 an hour.
- This should ensure that MHBA's can bill for travel time to ensure access to hard to reach families.
- There is also a proven audit risk with the way that the ratio of observation requirement is written. Face-to-face observation of the MHBA at a ratio of 1:40 hours of service should be calculated across time, and not per every 40 hours of work. It is impossible to insure that every consecutive 40 hours of work has one hour of observation given typical cancellations in children's schedule and given the scheduling complexities inherent in home-based services.