Update (September 12, 2025):
CBH has prepared this frequently asked questions (FAQ) document regarding the IBHS-ABA realignment addressed in Provider Bulletins 25-24 and 25-25.

QUESTIONS

What are the upcoming changes to the MNC for IBHS?

Starting **September 1, 2025**, CBH will implement new **medical necessity criteria (MNC)** to enhance the effectiveness and oversight of Intensive Behavioral Health Services (IBHS), ensuring treatment is clinically justified and family-centered. Changes include admission criteria changes for ABA Early Childhood Intensive Treatment (ABA-ECIT) and ABA One-to-One services (ABA 1:1) delivered in a center.

CBH has updated its MNC to include additional clinical benchmarks and contextual criteria for youth entering these services. This includes more robust clinical documentation to demonstrate:

- A clear diagnosis with functional impairment that supports the level of care
- Appropriateness of the setting (home, school, or center) based on clinical need
- Justification for early intensive models in children under age six

Please Note: *This MNC was circulated for public comment before final submission to OMHSAS.*

Who is responsible for informing the School District about these changes?

CBH has been communicating with the School District leadership, including representatives from the Office of Diverse Learners and the Office of Prevention and Intervention, regarding these changes. CBH's school-based liaison team will provide additional information about IBHS in schools.

Are there changes to the SDOH tools?

For information about the changes to providers' social determinants of health (SDOH) tool, please see **CBH Provider Bulletin 25-26** regarding implementing screening tools and submitting performance measure data for statewide OMHSAS PIP. This bulletin outlines the requirements for implementing screening tools and data submission for performance measures. The CBH Quality Management Department oversees this work, and any further feedback/questions may be directed to **CBH.PIP@phila.gov**.

Are there changes to how treatment plans and family goals should be written?

As **outlined in the Provider Bulletin**, CBH will be looking for goals that specifically identify the caregivers involved, with a focus on transfer of skills that the child is working on towards generalization across settings (for example, there may be one goal for a child to develop a specific skill and a second goal for the caregiver to build competency in supporting that skill being used in the home/community). The purpose isn't simply to name family involvement but to ensure active caregiver participation that enhances generalization of skills across settings.

The following are recommendations on how to identify and interpret those goals effectively:

- **Explicit caregiver identification**: Goals should directly refer to "parent," "guardian," "caregiver," or names like “mom/dad”—this helps ensure clarity and counts toward compliance.
- **Skill transfer focus**: Goals must support the caregiver in helping the child generalize treatment skills outside of session (e.g., reinforcement strategies, behavior response tactics).
- **Behavioral/educational collaboration**: If the child has an IEP, goals may include supporting caregivers in coordinating with school staff or modeling skills at home that align with classroom strategies.

Training can occur in other settings (e.g., school, community location) if the parent/caregiver is actively present and engaged.

Is CBH looking into how different socioeconomic statuses impact family Engagement?

Since CBH is the Medicaid payor for Philadelphia County, we are aware that there is variability in socioeconomic status among our members. However, we believe that all families can be empowered to support their child’s behavioral health needs and acquire new skills to bring out the best in their child.

Will CBH accept telehealth to facilitate cross-setting treatment?

Telehealth can be used in a limited way, but IBHS is still aligned around a wrap-around model of meeting families where they are. If children receive behavioral treatment, the preference is for regular, ongoing face-to-face contact with all parents and caregivers, particularly when the service aligns with a behavioral model that requires change in environments to meet children’s ITP goals. The appropriateness of telehealth will also depend on the type of goal being worked on and the ability to implement the specific treatment interventions via telehealth effectively.

If a child is discharged because parents are not participating, what level of care will they go to?

IBHS is an intensive service, as the name suggests. If families are looking for a less intensive service, there are additional options on the CBH continuum available, including, but not limited to, outpatient therapy and targeted case management. Recommendations for services should be individualized based on clinical need.

How do these changes affect enhanced Medical Necessity Reviews?

CBH will include a psychologist or physician advisor in reviewing medical necessity for any request for a youth with an IEP or 504 for supports in a school setting, and for any request for ABA for youth over 12.

Will CBH monitor any increase in mobile team requests for schools or CRC claims for school-aged youth?

Yes, CBH can view mobile crisis utilization through the claims process.

How will families be notified of this shift in family engagement expectations?

CBH supports family psychoeducation and engagement through ISPT meetings, but families' primary relationship is with the treating provider. CBH expects that our provider network continuously educates families on the CBH continuum, medical necessity, and family participation/engagement expectations for all types of behavioral health treatment. Many providers have family participation agreements or handbooks that they review and have families sign at the start of treatment to outline expectations for partnering during their child's episode of care.

Are there changes to the medical necessity criteria for IBHS – Individual Services as well as ABA?

No changes to the MNC for IBHS – Individual Services are being made at this time.

Are the definitions for "setting" or "cross setting" changing?

While the current MNC for IBHS – Individual Services does not explicitly define "cross-setting" as a standalone descriptive term, CBH's recent policy enhancements clarify its intent to operationalize IBHS as a service designed to span multiple life domains, including home, school, and community. This clarification is significant in the context of the ABA realignment.

Regionalized IBHS providers should interpret "designed to be a cross-setting service" as a functional, not literal, directive. This directive is intended to ensure that treatment planning addresses a child's broader ecological needs and enables skill transfer across systems. In this model, the integration of family goals is a required component of cross-setting applicability—even if the current service delivery happens primarily in one setting.

If there is a "one-family goal" only as opposed to "at least two-family goals," should regionalized IBHS providers expect to get a denial for an authorization for BC or MT services under IBHS – Individual Services or "just" BHT services under IBHS – Individual Services?

Yes—Effective September 1, 2025, all authorization requests for IBHS must include an Individual Treatment Plan (ITP) that identifies at least two-family goals, regardless of which service type (BC, MT, or BHT) is requested.

Would regionalized IBHS providers only be able to satisfy the change in authorization practice to act on the "at least two-family goals" as opposed to "at least two family" treatment objectives or "at least two family" interventions?

Effective September 1, 2025, the requirement that all authorization requests include at least two-family goals refers to goal statements within the Individual Treatment Plan (ITP), not necessarily to two treatment objectives or two separate interventions targeted at family members.

Regionalized IBHS providers must act on the requirement of "at least two-family goals", not on whether two separate objectives or interventions are focused on the family. Goals may be supported by a single intervention or embedded across multiple objectives, as long as:

- they're explicitly written in the plan,
- they're clinically linked to the youth's treatment trajectory, and
- they meet CBH's criteria for cross-setting relevance and caregiver impact.

Will SDOH goals and treatment goals both satisfy changes in authorization practices?

Under the ABA realignment and updated IBHS authorization practices, CBH clearly expects that at least two-family goals must be included in the Individual Treatment Plan (ITP) for services to be authorized—regardless of the setting of service delivery. However, CBH does not strictly limit these goals to clinical treatment goals.

CBH recognizes that goals aligned with SDOH—such as facilitating transportation access, financial literacy, or healthy routines—can be highly relevant and clinically supportive of a youth's treatment trajectory. If "Mom will walk with [client]" and "Dad will open a checking account" are written as family goals that support increased caregiver stability, availability, and modeling of pro-social behaviors, they *can* meet the standard—**provided they are clearly linked to functional outcomes for the youth and align with treatment planning rationale.**

Key Considerations to Ensure Alignment with Authorization Standards:

- Goals must demonstrate a connection to the youth's functional needs or skill development, even if indirectly.
- Documentation should articulate how SDOH goals support treatment continuity and generalization across settings.
- Avoid overly generic or aspirational goals—ensure they are measurable, realistic, and relevant to the youth's clinical presentation.