SUMMARY OF EXPRESS TERMS

This notice of proposed rulemaking amends 10 NYCRR subpart 69-4, which governs the Early Intervention Program (EIP), to: add mental health practitioners to and remove school psychologists from the list of Early Intervention qualified personnel to conform to the approved Early Intervention (EI) "Early and Periodic Screening, Diagnostic and Treatment" (EPSDT) Medicaid State Plan; align the definition of elevated blood lead level with the current New York Codes, Rules and Regulations (NYCRR) Title 10 Part 67 definition; reduce the required number of clock hours of experience for qualified personnel; require a comprehensive quality assurance plan; update the term "family assessment;" clarify written order and written recommendation requirements; and clarify documentation requirements for EI services. The proposed amendments also clarify reimbursement requirements for EI evaluations and services; define group EI services; and set forth documentation requirements relating to group services. Specific amendments are as follows:

Section 69-4.1(m), (o), (q), and (ag) are amended to add definitions for the terms "collateral visits" and "group early intervention services;" to correct a typographical error in a cross reference; to update the term "family assessment" to read "family-directed assessment;" and to clarify service delivery in natural environments."

Section 69-4.1(al)(16)-(24) are amended to add licensed mental health counselors, licensed marriage and family therapists, licensed psychoanalysts, and licensed creative arts therapists as qualified personnel to provide early intervention services, and to remove school psychologists from the definition of qualified personnel effective July 1, 2024.

Section 69-4.3(g)(1)(xvii) is amended to add the option of a follow-up screening or diagnostic audiological evaluation to rule out hearing loss based on risk factors or failure of initial newborn infant hearing screening. Section 69-4.3(g)(2)(iii) is amended to align with 10 NYCRR Part 67, Lead Poisoning Prevention and Control, which reduces the definition of elevated venous blood lead level to 5mcg/dl.

Section 69-4.4(b) is amended to update the time frame in which introductory service coordination training must be completed; the new period will be within four weeks of Department approval and prior to furnishing services.

Section 69-4.5(a) is amended to remove an outdated deadline; reduce the required number of documented clock hours of experience delivering services to children under five years of age from 1,600 hours to 1,000 hours; remove the requirement for discipline-specific quality assurance plans and to require an overall quality assurance plan developed and overseen by the agency director or county Early Intervention Official; and to require an EI agency to employ all required staff before agency authorization will be granted by the Department.

Section 69-4.5(b) is repealed, as licensed behavior analysts and certified behavior analyst assistants are now recognized as qualified providers of Early Intervention services, so there is no need for this provision. Similarly, Section 69-4.11(a)(10)(v), (vi), (xiii) is amended to remove reference to ABA aides and reflect that licensed behavior analysts and certified behavior analyst assistants are recognized as providers of Early Intervention services. Section 69-4.30(c)(13) is also amended to remove the reference to ABA aides.

Section 69-4.7(i)(3) and (p)(3) are amended to update the name of a program to the Children and Youth with Special Health Care Needs Program, in conformance with recent regulatory changes under Title 10 of the NYCRR.

Section 69-4.8(e)(2) is amended to clarify that evaluation instruments must be administered following all protocols in the examiner's manual.

Section 69-4.10(a)(1)(iv) is amended to ensure that group EI services are provided to EI eligible children at the site of an approved EI provider, and to require that the site is documented in the provider's current DOH approval.

Section 69-4.11(a)(10) is amended to clarify the term "frequency" means the number of days or sessions per week the service will be provided and to clarify that parents must object in writing to the notification from the Committee on Preschool Special Education (CPSE) that their child is potentially eligible for services under section 4410 of Education Law, to align with federal Office of Special Education Program (OSEP) requirements that oral objection is not sufficient. Likewise, Section 69-4.20(b)(1)(i) is amended to clarify that parental objection to notification of the CPSE must be in writing, to align with these federal OSEP requirements.

Section 69-4.26(b)(8) is amended to clarify that written orders apply to multidisciplinary and supplemental evaluations.

Section 69-4.26 includes several amendments to the session note requirements: subdivision (b)(12) is amended to clarify that parents are to sign service logs, not session notes; subdivision (c) is amended to require additional specificity in session notes and align with documentation requirements to be added to section 69-4.30(c)(8)(vii); and subdivision (d) is amended to require session notes to include the date the session note was created.

Section 69-4.30 is amended to clarify reimbursement requirements for EI screenings; clarify that supplemental evaluations are driven by the Individualized Family Service Plan (IFSP); clarify supplemental evaluations must be in accordance with the child's IFSP; clarify multidisciplinary evaluation reimbursement and additional multidisciplinary or supplemental evaluations provided within a 12-month period; clarify that collateral visits are intended to provide the parent and/or caregiver with the tools needed to assist their eligible child; and fix typographical errors and update cross-references. In addition, language is added to clarify that when determining whether hearing loss is present, supplemental audiological evaluations may take place prior to an IFSP for certain infants. Finally, language is repealed to make changes to ensure group EI services are provided appropriately and will benefit each eligible child participating in group services.

Several sections are amended to add the word "directed" before the term "family assessment" for purposes of clarification and consistency in terminology, including: Section 69-4.7(p)(3); Section 69-4.17(a)(1); Section 69-4.26(a)(8); and Section 69-4.30(c)(2)(i).

Additionally, several sections are amended solely to correct typographical errors, including: Section 69-4.10(a)(1)(iii); and Section 69-4.30(c)(7).

Pursuant to the authority vested in the New York State Department of Health by Public Health Law Section 2559-b, Subpart 69-4 of Chapter II of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivisions (m), (o), (q), (ag), and (al) of section 69-4.1 are amended to read as follows:

(m) *Early intervention services* means:

* * *

(2) Early intervention services include:

* * *

(xx) *collateral visits* means services that are provided to the child and family/parent/caregiver in accordance with the child's IFSP.

(xxi) *group early intervention services* means the provision of physical therapy, occupational therapy, speech-language therapy, applied behavior analysis, or special instruction early intervention services by appropriate qualified personnel to eligible children in a group consisting of two (2) to ten (10) children.

* * *

(o) Evaluation means the multidisciplinary procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility for the Early Intervention Program, including identifying the level of functioning of the child in each of the following areas of development: cognitive, physical, communication, social or emotional, and adaptive development that is consistent with the level of developmental delay as defined in subdivision [(h)](i) of this section. An initial evaluation is the evaluation to determine a child's initial eligibility for the program.

* * *

(q) *Family-directed assessment* means a voluntary family-directed assessment conducted by qualified personnel to identify family priorities, resources and concerns, which the family decides are relevant to their ability to enhance their child's development, and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability.

* * *

(ag) *Natural environment* means settings that are natural or normal for the child's age peers who have no disability, including the home, a relative's home when [care is delivered] the child is being cared for by the relative, child care setting, or other community setting in which children without disabilities participate.

Paragraphs (16) through (24) of subdivision (al) of Section 69-4.1 are amended to read as follows:

[(16) registered dietitians and certified dietitians/nutritionists;]

([17]16) school psychologists, only through June 30, 2024;

([18]17) clinical and master social workers;

(18) licensed mental health counselors;

(19) licensed marriage and family therapists;

(20) licensed psychoanalysts;

(21) licensed creative arts therapists;

(22) registered dietitians and certified dietitians/nutritionists;

([19]23) special education teachers and teachers of students with disabilities, birth to grade two;

([20]24) speech and language pathologists;

([21]25) teachers of the blind and partially sighted, teachers of the blind and visually handicapped, and teachers of the blind and visually impaired;

([22]26) teachers of the deaf and hearing impaired and teachers of the deaf and hard of hearing;

([23]27) teachers of the speech and hearing handicapped and teachers of speech and language disabilities; and,

([24]28) other categories of personnel as designated by the Commissioner.

Subparagraph (xvii) of paragraph (1) and subparagraph (iii) of paragraph (2) of subdivision (g) of section 69-4.3 are amended to read as follows:

(g) Referrals of children at risk of having a disability shall be made based on the following medical/biological risk factors:

(1) Medical/biological neonatal risk criteria, including:

* * *

(xvii) risk of hearing loss based on family history, including syndromal presentation, or failure of initial newborn infant hearing screening and the child is in need of follow-up screening or diagnostic audiological evaluation;

* * *

(2) Medical/biological post-neonatal and early childhood risk criteria, including:

* * *

(iii) elevated venous blood lead levels (at or above [15]5 mcg/dl);

Subdivision (b) of section 69-4.4 is amended to read as follows:

(b) Service coordinators shall participate in the introductory service coordination training session sponsored or approved by the Department of Health[, in the first three months and by no later than one year of direct or contractual employment as an early intervention service coordinator, provided that training sessions are offered and accessible in locations with reasonable proximity to their place of employment at least three times annually] within four weeks following direct or contractual employment as an early intervention service coordinator or Department approval, whichever is earlier, and such training shall be completed, documented and submitted prior to furnishing services.

* * *

Subdivision (a) of Section 69-4.5 is amended to read as follows:

(a) Individuals and agencies shall apply to the Department for approval to provide evaluations, service coordination services, or early intervention services. The Department may reapprove providers, but no more frequently than every five years from the date of approval or subsequent reapproval. Upon receipt of notification from the Department, an agency or individual shall apply for reapproval if the agency or individual wishes to continue providing services in the early intervention program. The Department shall consider applications for approval and reapproval utilizing the criteria set forth in subdivision (4) of this section.

* * *

(3) [On or before September 1, 2010, a] All approved providers shall be in compliance with the criteria set forth in paragraph (4) of this subdivision.

(4) Approval and reapproval of individuals and agencies shall be based on the following criteria:

* * *

(iii) for individual providers, proof of current certificate, license, or registration in one of the disciplines set forth in subdivision (al) of section 69-4.1 and documentation of a minimum of [1,600] 1,000 clock hours prior to the date of application to the Department for approval, delivering such service to children under five years of age in an early intervention, clinical pediatric, early childhood education program, which may include relevant experience obtained as part of a supervised educational program and/or clinical internship as a prerequisite for professional licensure, certification, or registration, and provided that such experience must have included direct experience in delivering services to children with disabilities and their families:

* * *

(vi) for agency providers, a comprehensive quality assurance plan that is approved by the Department for [each type of] all services offered by the agency, including evaluations, early intervention services, and service coordination. The quality assurance plan shall include, but not be limited to, ensuring qualified personnel have appropriate and current licensure, registration, and certification as applicable; ensuring continuing education and training requirements are met; and addressing how the agency will ensure that all documentation requirements to support billing and

claiming for early intervention services are met. The agency program director shall be responsible for developing a quality assurance plan that is approved by the Department, for implementing such plan, and for monitoring that quality assurance requirements are met.

(vii) for agency providers, documentation that the agency has in its employment, or in accordance with this subparagraph, will have in its employment, the following personnel:

(*a*) a professional employed on a full time basis who shall serve as the program director for the agency whose duties may include early intervention program service delivery [in addition to] and shall include administration and oversight responsibilities, including submission and oversight of the quality assurance plan pursuant to subparagraph (vi) of this paragraph. The program director shall have a minimum of two years of full-time equivalent experience in an early intervention, clinical pediatric, or early childhood education program serving children ages birth to five years of age, provided that:

(*1*) such experience shall have included direct experience in delivering services to children with disabilities and their families; and

(*2*) at least one year of such experience shall have been in the delivery of services to children less than three years of age and their families.

(*b*) a minimum of two qualified personnel or service coordinators who meet qualifications established in section 69-4.4 of this [s]Subpart, in addition to the Early Intervention Program director, each of whom provides evaluations, service coordination, or services to individuals with disabilities for a minimum of twenty hours each per week.

(*c*) [a professional or professionals who hold a license, certification, or registration in the type of service offered by the agency whose responsibilities include monitoring and overseeing implementation of the quality assurance plan for that service as developed by the agency in accordance with subparagraph (vii) of paragraph (3) of this subdivision.

(*d*) for purposes of this subdivision, if the agency applying for initial approval has not, at the time of application, employed the personnel required in this paragraph, the agency may verify that it will employ such personnel within three months of approval and receive a conditional three months of approval. At the end of the three-month period, the agency shall submit documentation of the employment of such personnel in accordance with said requirements. If the agency does not provide sufficient documentation at the end of the three month period that it meets the requirements of this subparagraph, the agency's approval shall be void ab initio and the agency shall not be authorized to provide services in the Early Intervention Program.]

[(*e*)] an agency applying for reapproval shall, at the time of application, submit documentation that it has in its employment the personnel required in this subparagraph;

* * *

(ix) delivery of services on a twelve-month basis and flexibility in the hours of service delivery, including weekend and evening hours in accordance with eligible children's['] IFSPs;

* * *

Subdivision (b) of section 69-4.5 is REPEALED.

* * *

Paragraph (3) of subdivision (i) and paragraph (3) of subdivision (p) of section 69-4.7 are amended to read as follows:

(i) The service coordinator shall assist the parent in identifying and applying for benefit programs for which the family may be eligible, including:

* * *

(3) [Physically Handicapped Children's Program] Children and Youth with Special Health Care Needs Program;

* * *

(p) Upon determination of the child's eligibility for the Early Intervention Program, the initial service coordinator shall discuss the [individualized family service plan] IFSP process with the parent and shall inform the parent:

* * *

(3) that inclusion of family-directed assessment information is optional;

Paragraph (2) of subdivision (e) of section 69-4.8 is amended to read as follows:

(2) The multidisciplinary evaluation of the child shall utilize age-appropriate procedures and instruments on the list of standardized instruments approved by the department, unless

written justification is included in the evaluation report for why such instruments are not appropriate or available for the child. The most recent version of the evaluation instrument must be administered, scored, and reported following all protocols in the examiner's manual as issued by the test developer.

* * *

Subparagraphs (iii) and (iv) of paragraph (1) of subdivision (a) of section 69-4.10 are amended to read as follows:

(a) The Department of Health, State early intervention service agencies, and early intervention officials shall make reasonable efforts to ensure the full range of early intervention service options are available to eligible children and their families.

(1) The following models of early intervention service delivery shall be available:

* * *

(iii) Parent-child groups: a group [comprised] composed of parents or caregivers, children, and a minimum of one appropriate qualified provider of early intervention services at an early intervention provider's site or a community-based site (e.g., day care center, family day care, or other community settings). The site of the service must be listed on the IFSP with the name of the provider and contact information.

(iv) Group [developmental] early intervention services: the provision of early intervention services by appropriate qualified personnel to a group of eligible children at an approved early intervention provider's site or in a community-based [setting where children under three years of age are typically found (this group may also include children without disabilities)] site. Such provider's site or community-based

site must be identified in the provider's initial or amended application and documented in the provider's current Department approval.

* * *

Subparagraphs (v), (vi), and (xiii) of paragraph (10) of subdivision (a) of section 69-4.11 are amended to read as follows:

(a) *Individualized Family Service Plan (IFSP) Participation*

* * *

(10) The IFSP shall be in writing and include the following:

* * *

(v) a statement of specific early intervention services based on peer-reviewed research, to the extent practicable, including transportation and the mode thereof, necessary to meet the unique strengths and needs of the child and the family, including the frequency, intensity, length, duration, location and the method of delivering services. [If ABA services using ABA aides are to be provided to the child, the IFSP shall specify the number of hours of intervention to be delivered by such aides in accordance with section 69-4.25 of this subpart.] For purposes of this subparagraph frequency, intensity, length, duration, location and method shall be defined as follows:

(*a*) frequency shall mean the number of days or sessions per week the service will be provided;

* * *

(xiii) if applicable, establishment of a transition plan with the steps and services to be taken supporting the potential transition of the toddler with a disability to services provided under section 4410 of the Education Law, or to other services, including:

(*a*) discussions with and education of parents regarding potential options and other matters related to the child's transition, including:

(*1*) if the child is potentially eligible for services under section 4410 of the Education Law, the service coordinator shall notify the Committee on Preschool Special Education (CPSE) of the local school district in which the child resides of the child's potential transition for services under section 4410 of the Education Law, unless the parent objects to such notification [orally or] in writing. The service coordinator shall explain to the parent the procedures by which the parent may object to notification of the CPSE of the child's potential transition and the deadline for such objection;

* * *

Paragraph (1) of subdivision (a) of section 69-4.17 is amended to read as follows:

(a) The early intervention official shall make reasonable efforts to ensure that the parent is fully informed in their dominant language of and understand the rights and entitlement afforded them under the Early Intervention Program, including the right to:

(1) elect or decline to have the child screened and/or evaluated to determine eligibility for early intervention services and to participate in the voluntary family-directed assessment process;

Subparagraph (i) of paragraph (1) of subdivision (b) of section 69-4.20 is amended to read as follows:

(i) The parent shall be afforded at least thirty calendar days to object[, either orally or] in writing[,] to written notification to the CPSE of the child's potential transition.

Section 69-4.26 is amended to read as follows:

(a) Municipalities shall maintain an early intervention record for each child referred to the program which documents the performance of all activities required to be completed by early intervention officials or their designees on behalf of eligible children under Article 25 of Title II-A of Public Health Law. The early intervention record shall be maintained in a confidential manner in accordance with section 69-4.17(c) of this [s]Subpart. The early intervention record shall include the following:

* * *

(8) any evaluation and diagnostic reports, including family-directed assessments and any medical records and correspondence to/from primary care physician(s) that are part of the evaluation record and demonstrate ongoing physician involvement;

* * *

(b) Agency and individual providers shall maintain Early Intervention Program records for each eligible child for whom the provider is authorized to deliver service coordination services, evaluations, and early intervention services. The early intervention record shall be maintained in a confidential manner in accordance with section 69-4.17(c) of this [s]Subpart and shall

document the performance of activities required to be completed by the provider on behalf of the child and family, including:

* * *

(8) written orders or recommendations from specific medical professionals when required for the services being provided to the child; for the purposes of this section, written orders mean orders for any early intervention services where an order is required to initiate the service as authorized by the early intervention official, including but not limited to orders for multidisciplinary and supplemental evaluations;

* * *

(12) documentation necessary for submission and substantiation of early intervention claims for payment by the municipality, third party payer, including the medical assistance program, and state aid reimbursement, including recipient identification (name, sex, and age of child); information on any insurance policy, plan, or contract under which the child has coverage; unit and specific type of service provided; date(s) of service; a service log [signature of] signed by the parent or caregiver verifying the service was [delivered] received by the child on the date and during the period of time as recorded by the provider; ICD diagnostic code for the condition or reasons for which care is provided; where applicable, the appropriate procedure code(s) for the service(s) provided; and, the name, address, and license, registration, certification, or where applicable, national provider identification number, of the professional delivering the service; and

* * *

(c) (1) Individual providers who directly render services to a child and family, or an approved provider agency, shall maintain original signed and dated session notes, following each child

and family contact, which shall include the recipient's name, date of service, type of service provided, whether the service was provided individually or in a group (specify actual group size on the date of service), the setting in which the service was rendered, time the provider began delivering therapy to child and end time, brief description of the recipient's progress made during the session as related to the outcome contained in the [individualized family service plan]IFSP, name, title, [and]-signature and credentials, including license or certification number as applicable, of the person rendering the service, and date the session note was created; the dated signature and credentials, including license or certification number as applicable, of the supervising clinician as appropriate; and a service log signed by the parent or caregiver which documents that the service was received by the child on the date and during the period of time as recorded by the provider.

* * *

(d) Agency and individual providers of initial and/or ongoing service coordination services shall document all activities related to the performance of their duties as set forth in sections 69-4.6 and 69-4.7 of this [s]Subpart, including recipient's name; date of service; a description of the specific service coordination activity performed; name, date of contact, and purpose of contact for providers or others contacted on behalf of the child and family as necessary to implement the IFSP; start and end time for each contact; [and,] name, title and signature of the service coordinator, as applicable; and date the session note was created and the date the service coordination note was created. Session notes and service coordination notes must reflect unique information about the child and must be completed in advance of submitting a claim for services furnished.

Subdivision (c) of section 69-4.30 is amended to read as follows:

(c) Reimbursement shall be available at prices established pursuant to this section for the following early intervention program services:

(1) *Screening* as defined in section 69-4.1(an) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. A provider shall submit one claim for a screening regardless of the number of visits required to perform and complete a screening. [Reimbursement may be provided for up to two screenings of a child suspected of having a developmental delay in any 12-month period without prior approval of the early intervention official.] The Early Intervention Official shall approve any [additional] screenings provided to a child beyond the initial screening conducted in accordance with section 69-4.8 of this Subpart [within the twelve month period]. Reimbursement shall not be provided for screenings performed after a child has been found eligible for early intervention services.

(2) *Multidisciplinary evaluation* as defined in section 69-4.1[(n)](o) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. Reimbursable evaluations shall include [core] multidisciplinary evaluations and supplemental evaluations. A provider shall submit one claim for [a core] an evaluation (multidisciplinary or supplemental) [evaluation] regardless of the number of visits required to perform and complete the evaluation.

(i) A [*core*] *multidisciplinary evaluation* shall include a developmental assessment, a review of pertinent records and a parent interview as specified in section 69-4.8[(a)(4)](e)(3)(ii) of this Subpart, and may include a family-directed assessment.

(*a*) A *developmental assessment* shall mean procedures conducted by qualified personnel with sufficient expertise in early childhood development who are trained in the use of professionally acceptable methods and procedures to evaluate each of the developmental domains: physical development, cognitive development, communication development, social or emotional development and adaptive development.

(*b*) A *family-directed assessment* shall mean a voluntary, family-directed assessment conducted by qualified personnel who are trained in the use of professionally acceptable methods and procedures to assist the family in identifying their concerns, priorities and resources related to the development of the child.

(ii) *Supplemental evaluations* shall include supplemental physician or non-physician evaluations and shall be provided upon the recommendation of the [multi-disciplinary] IFSP based on input from the team conducting the [core] multidisciplinary evaluation and agreement of the child's parent. [A supplemental evaluation may also be provided in conjunction with the core evaluation by a specialist trained in the area of the child's suspected delay or disability who is present during the core evaluation as required by section 69-4.8(a)(3) of this Subpart and who provides an in-depth assessment of the child's strengths and needs in such area.] Supplemental evaluations provided [subsequent to the child's Individualized Family Service Plan (IFSP)] must be required by and performed in accordance with the child's IFSP as specified in section 69-4.8[(a)(13)](l) of this Subpart.

(*a*) *Supplemental physician evaluation* shall mean an evaluation by a physician licensed pursuant to article 131 of the Education Law for the purpose of providing

specific medical information regarding physical or mental conditions that may impact on the growth and development of the child and completing the required evaluation of the child's physical development as specified in section 69-4.8 [(a)(4)(i)(a)](f)(3)(i) of this Subpart, or assessing specific needs in one or more of the developmental domains in accordance with section 69-4.8[(a)(4)(iv)] (f) of this Subpart.

(*b*) *Supplemental non-physician evaluation* shall mean an additional evaluation for assessing the child's specific needs in one or more of the developmental domains in accordance with section 69-4.8 of this Subpart. Information obtained from this evaluation shall provide direction as to the specific early intervention services that may be required for the child for the IFSP team to determine whether the current team can address the concerns with the addition of another functional outcome or if additional services or specific interventions are required to meet the needs of the child. Supplemental non-physician evaluations may be conducted only by qualified personnel as defined in section 69-4.1(al) of this Subpart.

(*c*) A non-physician supplemental audiological evaluation may be performed for infants who have failed newborn hearing screening.

(iii)(*a*) [A]One multidisciplinary evaluation [consisting of a core evaluation and up to four supplemental evaluations (which may include any combination of physician and non-physician evaluations)] may be reimbursed within a 12-month period without prior approval of the Early Intervention Official to develop and implement the initial IFSP [and subsequent annual IFSPs]. The Early Intervention Official shall assess the need for and, if appropriate, approve and notify the department of any additional

[core] multidisciplinary or supplemental evaluations provided to a child within a twelve-month period. If additional [core] multidisciplinary or supplemental evaluations are necessary, such notice shall be provided on a monthly basis [on forms] in a format provided by the department. Additional [core] multidisciplinary or supplemental evaluations provided subsequent to the child's initial IFSP must be required by and performed in accordance with the IFSP as specified in section 69-4.8[(a)(13)](l) of this Subpart.

(*b*) Certain evaluation and assessment procedures may be repeated if deemed necessary and appropriate by the Early Intervention Official in conjunction with the required annual evaluation of the child's IFSP or more frequently in accordance with section 69-4.8[(a)(12)](k) of this Subpart. If additional evaluation or assessment procedures are necessary, the Early Intervention Official shall approve up to one more [core] multidisciplinary evaluation and two supplemental evaluations prior to the next annual IFSP. Such additional evaluations must be required by and performed in accordance with the child's IFSP as specified in section 69-4.8[(a)(13)](l) of this Subpart. Any additional evaluations within that period shall be based on the indicators specified in section 69-4.8[(a)(12),](k) [approved by] and shall first be approved by the Early Intervention Official and the Commissioner of Health of the New York State Department of Health; in assessing the need for such additional evaluations, the Early Intervention Official and the Commissioner of Health shall ensure that such additional evaluations are [and] required by and performed in accordance with the child's IFSP.

(3) *Service coordination* as defined in section 69-4.1(m)(2)(xii) of this Subpart. Service coordination shall be provided by appropriate qualified personnel, delivered in accordance with the child's IFSP, and billed in 15 minute units that reflect the time spent providing services in accordance with sections 69-4.6 and 69-4.7 of this Subpart, or billed under a capitation or other rate methodology as may be established by the Commissioner subject to the approval of the Director of the Budget and as specified in prior written notice provided by the Commissioner to Early Intervention Officials. Such written notice shall specify that any newly established rate methodology shall apply only to initial IFSPs and IFSP amendments made on or after the effective date of such written notice by the Commissioner. The rate methodology may be established on a per month, per week, and/or service component basis for providing service coordination services. When units of time are billed, the first unit shall reflect the initial five to fifteen minutes of service provided and each unit thereafter shall reflect up to an additional fifteen minutes of service provided. Except for child/family interviews to make assessments and plans, contacts for service coordination need not be face-to-face encounters; they may include contacts with service providers or a child's parent, caregiver, daycare worker or other similar collateral contacts, in fulfillment of the child's IFSP.

* * *

(5) Home and community-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or [parent(s) or other designated caregiver help the] collateral services that are provided in the context of the parent/caregiver-child dyad to help the child reach [his or her goals] their outcomes, as articulated in the child's IFSP. Home and community-based visits take

place at the child's home or other natural setting in which children under three years of age are typically found (including day care centers, other than those located at the same premises as the early intervention provider, and family day care homes). Reimbursable home and community-based individual/collateral visits shall include basic and extended visits.

(i) A basic visit is a minimum of 30 minutes and less than one hour in duration. Up to three (3) such visits provided by appropriate qualified personnel within different disciplines per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

* * *

(6) Office/facility-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or [parent(s) or other designated caregiver] collateral services that are provided in the context of the parent/caregiver-child dyad to help the child reach his or her outcomes, as articulated in the child's IFSP. Office/facility-based visits take place at an approved early intervention provider's site (including day care centers located at the same premises as the early intervention provider). A basic office/facility-based visit is a minimum of 30 minutes and less than one hour in duration. Up to one (1) visit per discipline and no more than three (3) office/facility-based visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(7) Parent-child group visit. This shall mean the provision of early intervention services in a group [comprised] composed of parent(s) or other designated caregivers and eligible children, and a minimum of one appropriate professional qualified to provide early

intervention services at an early intervention provider's site or a community-based site (e.g., day care center[,] or family day care[, or other community settings]). Up to one (1) visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(8) [Basic group developmental intervention] Group early intervention service visit. This shall mean the provision of physical therapy, occupational therapy, speech-language therapy, applied behavior analysis, or special instruction early intervention services by appropriate qualified personnel to eligible children in a group [which may also include children without disabilities,] at an approved early intervention provider's site [or in a community-based setting where children under three years of age are typically found] or at a day care facility duly licensed in New York State .

(i) Up to [one (1)] 120 minutes of group [developmental] early intervention [visit] services per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official. Any additional group sessions in the same day shall be approved by the Early Intervention Official.

(ii) [For purposes of subparagraph (i) of this paragraph and subparagraphs (i) of paragraphs (9) through (11) of this subdivision, a group developmental intervention visit shall include a basic visit as described in this paragraph, an enhanced visit as described in paragraph (9) of this subdivision, a basic with one-to-one aide visit as described in paragraph (10) of this subdivision, or an enhanced with one-to-one aide visit as described in paragraph (11) of this subdivision.] A group early intervention service session shall be a minimum of 60 minutes and a maximum of 120 minutes in length and in accordance with the child's IFSP.

(iii) Groups shall consist of two to ten eligible children. Use of a one-to-one aide should be based on clinical appropriateness.

(iv) Groups shall be provided by, at a minimum, one approved and appropriately qualified early intervention provider and one assistant.

(v) Groups shall consist of children with similar IFSP outcomes and include appropriate therapeutic approaches.

(vi) Children participating in a group early intervention service shall not also receive individual services (including push-in/pull-out services) while the group is in session.

(vii) Session notes shall be provided for each child as an individual, not for the group as a whole, and shall include, at a minimum:

(*a*) eligible child's name;

(*b*) specific type of service provided;

(*c*) individual or group service;

(*d*) group size if applicable;

(*e*) setting in which the group service was rendered;

(*f*) date and time the service was rendered, including start and end times;

(*g*) brief description of the student's progress made by receiving the service during the session;

(*h*) name, title, signature, and credentials of the person furnishing the service; and

(*i*) signature and credentials of supervising clinician as appropriate, dated within 45 days of the date of service.

[(9) Enhanced group developmental intervention visit. This shall mean a group developmental intervention visit as defined in paragraph (8) of this subdivision provided

to a child who, due to age, significant medical needs (such as major feeding difficulties, severe orthopaedic impairment), significant behavior management needs and/or level of developmental functioning, require significantly more time and attention from adults during group activities.

(i) Up to one (1) group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(10) Basic group developmental intervention with one-to-one aide visit. This shall mean the provision of early intervention services by appropriate qualified personnel to eligible children in a group which may also include children without disabilities, with attendance at the group developmental intervention session by an additional aide or appropriate qualified personnel. This visit must be provided at an approved early intervention provider's site or in a community-based setting where children under three years of age are typically found.

(i) Up to one (1) group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(11) Enhanced group developmental intervention with one-to-one aide visit. This shall mean a group developmental intervention with one-to-one aide visit as defined in paragraph (10) of this subdivision provided to a child who, due to age, significant medical needs (such as major feeding difficulties, severe orthopaedic impairment), significant behavior management needs and/or level of developmental functioning, require significantly more time and attention from adults during group activities.

(i) Up to one (1) group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.]

[(12)] (9) Family/caregiver support group visit. This shall mean the provision of early intervention services by appropriate qualified personnel to a group of parents or other designated caregivers (such as foster parents, day care staff) and/or siblings of eligible children for the purposes of:

(i) enhancing their capacity to care for and/or enhance the development of the eligible child; and/or

(ii) provide support, education, and guidance to such individuals relative to the child's unique developmental needs. Up to two (2) visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official (for example, one (1) for parents or other designated caregivers and one (1) for sibling(s) in a given day).

[(13)] (10) ABA services. [This shall mean services delivered by an ABA aide employed by and under the supervision of an agency provider approved in accordance with 69-4.25 of this subpart to deliver ABA services in accordance with requirements set forth in section 69-4.25 of this subpart. The price established pursuant to this section shall include direct and indirect supervisory time, team meetings and training.] ABA services shall be billed [by the day and in increments of 60 minutes] as either basic or extended visits, as described in subdivision (c) paragraph (5) of this section, up to and in accordance with the hours of service as specified the child's IFSP.

[(14)] (11) The Early Intervention Official shall approve and notify the department of any visits provided in addition to those described in paragraphs (5) through [(12)](11) of this subdivision as may be required by and provided in accordance with the child's IFSP. If such additional visits are necessary, such notice shall be provided on a monthly basis on forms provided by the Department.

Regulatory Impact Statement

Statutory Authority:

Public Health Law (PHL) § 2550(1) establishes the Department of Health (Department) as the lead agency responsible for the general administration and supervision of providers and services under the Early Intervention Program (EIP), and PHL § 2550(2) authorizes the Department to establish standards for evaluators, service coordinators, and providers of early intervention services and requires the Department to monitor agencies, institutions, and organizations providing early intervention services to ensure compliance with such standards.

Legislative Objectives:

The EIP implements Part C of the federal Individuals with Disabilities Education Act (IDEA). The legislative objectives of the EIP include providing a coordinated, comprehensive array of services that enhance the development of infants and toddlers with disabilities, thereby minimizing the need for later special education services, in compliance with federal and state laws.

Needs and Benefits:

The proposed rule will conform the State's EIP regulations to federal regulations and amendments to PHL, as well as align with the current State Medicaid plan for Early Intervention (EI) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and federal Office of Special Education Programs (OSEP) directives to the Department, as the State implementing agency for IDEA Part C, regarding parental consent requirements. The proposed rule changes are in relation to definitions; additional practitioner types; provider approval;

evaluations; service delivery, including documentation requirements and parameters for group service delivery; clarification on reimbursement; and aligning with current Lead Poisoning Prevention and Control levels.

The proposed regulations also make clarifying changes, including adding the word “directed” to the term family assessment, updating regulatory references, eliminating applied behavior analyst aides to match prior regulatory updates, and correcting typographical errors.

These proposed amendments, which will conform the regulations to State and federal law, current Medicaid State Plan requirements, and OSEP guidance, will assist the municipalities and EIP providers by reducing confusion regarding regulatory oversight of the program, insofar as State EIP regulations will become up to date with current federal and State law.

Costs for the Implementation of, and Continuing Compliance with the Regulation to the Regulated Entity:

No additional cost for providers of EIP services is anticipated to result from the proposed rule, as they provide conforming changes based on the PHL and federal rules and guidance.

In addition, removing the requirement that agencies have one Quality Assurance (QA) professional for each approved EI service type and addition of the requirement that the EI Program Director oversee the QA plan for all approved EI services, will give agencies the flexibility to potentially achieve savings by reducing the hours of QA professionals and/or increasing program revenue through the QA professionals' availability to provide services.

Costs to the Agency, the State and Local Governments for the Implementation of and Continuing Compliance with the Rule:

There is potential savings to the State and Local Governments of $100,000 annually related to holding the group size for early intervention services to two to ten children.

Local Government Mandates:

The proposed rule does not impose any new duty upon any county, city, town, village, school district, fire district, or other special district, as all existing EIP requirements on localities that administer the EIP at the local level will remain unchanged by the amended regulations.

Paperwork:

The proposed rules do not impose any new paperwork requirements upon any state or local governments.

Duplication:

The proposed rules do not duplicate, overlap, or conflict with relevant rules and other legal requirements of the state and federal government.

Alternatives:

Amendments to these sections are necessary to comply with federal regulations, the updated approved Medicaid State Plan for Early Intervention (EI) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, and OSEP guidance. However, after careful review and consideration of the public comments and EI data, the Department has amended the

regulation to increase the permissible group size for EI services from eight to ten children and to extend the end date for discontinuing participation of school psychologists in the EIP.

Federal Standards:

The proposed amendments will be consistent with the federal standards at 34 CFR Parts 300 and 303.

Compliance Schedule:

The proposed rules will be effective immediately upon adoption. These proposed rules will conform the regulations to existing requirements in federal regulations and federal and state statutes.

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Statement in Lieu of Regulatory Flexibility Analysis

No Regulatory Flexibility Analysis is required pursuant to section 202-b(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping, or other compliance requirements on small businesses or local governments.

Statement in Lieu of Rural Area Flexibility Analysis

A Rural Area Flexibility Analysis for these amendments is not being submitted because amendments will not impose any adverse impact or significant reporting, record keeping, or other compliance requirements on public or private entities in rural areas. There are no professional services, capital, or other compliance costs imposed on public or private entities in rural areas as a result of the proposed amendments.

Statement in Lieu of Job Impact Statement

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

Summary of Assessment of Public Comment

The New York State Department of Health (NYSDOH) received 43 comments from various Early Intervention Program stakeholders, including Early Intervention provider agencies, professional associations, county associations, the City of New York, provider representatives, and advocates for children's services. The Early Intervention Program (EIP) furnishes services to eligible children from birth to age three years with developmental delays or disabilities and their families. Comments opposed to proposed changes focused on concerns about the permissible group size for early intervention group services, and the elimination of certified school psychologists from the list of qualified EIP providers. A notice of revised rulemaking is being filed to help address some of these comments. Below is a summary of some of the public comments that were received.

COMMENT: Several commenters firmly opposed limiting the maximum size of an early intervention group to eight (8) children, from previous policy guidance permitting up to twelve (12) toddlers in a group, citing financial concerns or potential capacity issues. One commenter cited staffing ratios found in New York City day care regulations (Article 47, section 47.23) as more appropriate for delivery of early intervention (EI) services to toddlers in a group setting.

RESPONSE: The EIP serves infants and toddlers with developmental delays or disabilities and differs from supervision of children in a day care setting. An analysis of group EI services furnished in 2022 showed that 95% of groups consisted of ten (10) children or fewer. Therefore, the proposed regulation has been amended to allow for a maximum group size of ten (10) young children. This better aligns with ratios for special education services and recognizes absenteeism concerns.

COMMENT: Thirteen commenters opposed elimination of certified school psychologists from the list of qualified EIP providers, noting they provide evaluations and special instruction services to children in the EIP. Some commenters requested additional time to effectuate this change.

RESPONSE: Certified school psychologists participated in the EIP under a series of time-limited amendments to NYS Education Law, as employees of approved EI agencies. The removal of certified school psychologists in the proposed regulation aligns with currently approved Medicaid State Plan (18-0039), which outlines practitioner types authorized to provide evaluations and services in the EIP. Information regarding this Medicaid State Plan has been shared with EI stakeholders since September 2019. Additional notification to the field regarding discontinuing participation of school psychologists in the EIP was issued in April 2022. Participation of school psychologists in the EIP will end with the sunset of the current temporary amendment to NYS Education Law at the end of June 2024. As such, the proposed regulation has been amended to reflect that certified school psychologists can only provide EI services through June 30, 2024.

Assessment of Public Comment

Public comments were received from 43 various stakeholders including but not limited to Early Intervention (EI) provider agencies, EI associations, professional associations, county associations, the City of New York, provider representatives, and advocates for children's services. The Department provided updates on proposed regulations to stakeholders at quarterly Early Intervention Coordinating Council (EICC) meetings. Additionally, to comply with federal requirements under the Individuals with Disabilities Education Act (IDEA), the New York State Department of Health (Department) convened a public hearing. An in-person public hearing was held at the New York State (NYS) Convention Center, Meeting Room 1, Empire State Plaza in Albany, New York on November 7, 2022 from 11:00 AM to 1:00 PM. One individual attended the public hearing and presented comments. All public comments received along with the Department's responses are summarized below, in order of proposed regulatory changes by section.

Section 69-4.1 – Definitions

EI Qualified Providers

Mental health practitioners

COMMENT: Thirteen commenters opposed the addition of four (4) mental health practitioner types (licensed mental health counselors, marriage and family therapists, psychoanalysts, and creative arts therapists) as EI providers.

RESPONSE: The need to address mental health and social-emotional development of children in the Early Intervention Program (EIP) is well established and was the subject of a 2017 guidance document developed jointly by the NYS Early Intervention Coordinating Council and

NYS Council on Children and Families Early Childhood Advisory Council. These additional licensed practitioners, working within their scope of practice, will add to the capacity of the EIP to provide psychological services to support children and their families enrolled in the EIP. This change is consistent with federal Early Intervention Program requirements for qualified personnel at 34 CFR section 303.13. Additional guidance regarding the role of licensed mental health practitioners in the EIP will be forthcoming.

COMMENT: Three commenters supported the inclusion of licensed mental health counselors (LMHCs) in the definition of qualified personnel for the EIP. One commenter noted that additional guidance is needed on the role of these providers. Another noted that LMHCs became a licensed profession in 2002 and there are nearly 10,000 licensed mental health counselors in New York State.

RESPONSE: This comment is noted. Additional guidance regarding the role of licensed mental health counselors in the EIP will be forthcoming.

School psychologists (certified)

COMMENT: Thirteen commenters opposed elimination of certified school psychologists from the list of qualified EIP providers, noting they provide evaluations and special instruction services to children in the EIP; some commenters requested additional time to effectuate this change.

RESPONSE: Certified school psychologists participated in the EIP under a series of time-limited amendments to NYS Education Law, as employees of approved EI agencies. The amendment to the regulation is to align with the currently approved Medicaid State Plan (18-

0039), which outlines practitioner types authorized to provide evaluations and services in the EIP. Information regarding this Medicaid State Plan has been shared with EI stakeholders since September 2019. Additional notification to the field regarding discontinuing participation of school psychologists in the EIP was issued in April 2022. Participation of school psychologists in the EIP will end with the sunset of the current temporary amendment to NYS Education Law at the end of June 2024.

Psychological services may be provided in the EIP by licensed psychiatrists, psychologists, clinical social workers, master social workers under the supervision of clinical social workers, and, going forward, by mental health counselors, marriage and family therapists, psychoanalysts, and creative arts therapists. Guidance regarding the addition of four licensed mental health practitioners to the EIP will be forthcoming.

Collateral visits
Note: See also Collateral visits Section 69-4.30

COMMENT: Three commenters opposed including "or to the parent/caregiver" in connection with defining collateral visits, noting that best practice is inclusion of the family/caregiver in EI visits and concerns about billing where the parent/caregiver is the only recipient of an EI service.

RESPONSE: The Department agrees with the clarification that such visits are to be provided in the context of the parent/caregiver-child dyad and has made this change in the proposed regulations. Collateral services provided in the context of the parent/caregiver-child dyad are visits intended to provide the parent and/or caregiver with the tools needed to assist their eligible child and must be for the child's direct benefit. Persons receiving collateral services, which include psychological services, social work, and special instruction to support the child's development, must be identified in the individualized family service plan (IFSP).

Group early intervention services

COMMENT: A commenter recommended adding minimum and maximum number of children allowed to qualify as a group early intervention service to the definition of group EI services.

RESPONSE: The Department agrees with this recommendation and has amended the regulation to expressly state that the maximum number of children for group services is ten (10).

COMMENT: Twelve commenters opposed revisions to the group EI service delivery model, including changing the term "group developmental model" to "group early intervention service."

RESPONSE: The shift to group early intervention services is intended to provide greater specificity to therapeutic services being furnished to eligible children in the EIP who are receiving services in a group setting. For example, children in a group might receive speech-language services provided by a licensed speech-language pathologist, or a group might receive special instruction from a certified special educator. Additionally, this shift clarifies that group EI therapy services can be led by various qualified personnel with expertise in specific disciplines to meet the needs of the children in the group based on their IFSPs and has the potential to help address capacity issues in the EIP.

Service coordinator training

COMMENT: Two commenters supported the requirement that new service coordinators complete basic service coordination training within four weeks of direct or contractual employment as an EI service coordinator and suggested clarifying language regarding timing for such approval to allow for municipalities to implement this requirement in advance of a formal Department approval process.

RESPONSE: The Department agrees with the recommendation regarding the approval process and has amended the regulation to allow for completion of service coordinator training in advance of Departmental approval.

Section 69-4.5(a)
Reduction in minimum clock hours – qualified personnel

COMMENT: Five commenters expressed concern about the reduction in the minimum number of clock hours of clinical experience delivering services to children under five years of age from 1,600 hours to 1,000 hours for EI providers.

RESPONSE: The Provider Workforce Capacity Task Force of the state Early Intervention Coordinating Council (EICC) and the full EICC carefully considered the reduction in the required number of clock hours of clinical experience in connection with quality of care. The Department agrees that provider preparation and quality of EI services are of paramount importance. The Department also recognizes that in the years since the inception of the 1,600-hour requirement, educational requirements for several professions have advanced to higher level degrees. In addition to the continuing education requirements most practitioners are required to fulfill to maintain their professional licensure/registration and/or certification, the Department requires that approved EI providers complete training on various topics and will continue to expand offerings to support the competency of EI providers to delivery high quality services to children and families.

COMMENT: Four commenters supported the reduction in clock hours from 1,600 to 1,000 as a requirement for on-the-job experience, noting the importance of supporting and supplementing rendering providers.

RESPONSE: The Department thanks the commenters for their support.

Section 69-4.5

Quality assurance

COMMENT: Three commenters expressed concern regarding the modification of quality assurance requirements, noting that discipline-specific quality assurance professionals who understand the service being delivered are necessary to maintain internal controls of service quality.

RESPONSE: Oversight of all EI service delivery remains in place at the local level. However, a broader approach to quality assurance plans recognizes that there are certain common elements of quality assurance plans across disciplines, such as ensuring that providers maintain their licensure, registration and/or certification as applicable, and that timelines and documentation requirements are met to support billing and claiming for EI services. The proposed amendment is intended to facilitate the ability of local EI counties and agencies to hire or contract with qualified personnel to help mitigate capacity issues. Under the current regulations, counties are precluded from hiring or contracting with qualified practitioners on a full time or per diem basis to serve children in the EIP when another practitioner in that discipline is not employed to oversee the qualified provider.

COMMENT: One commenter suggested that the agency program director be required to have the ability to consult with a discipline-specific professional with the correct licensure and appropriate expertise when needed to provide effective oversight of EI services.

RESPONSE: No changes to the regulation are needed in response to this comment.

Section 69-4.8

Evaluation instruments

COMMENT: Three commenters supported the clarification regarding appropriate use of evaluation instruments when conducting an evaluation and suggested additional language to further explicate this requirement, including use of the most current version of the test instrument and that results be scored and reported appropriately.

RESPONSE: The Department agrees with this recommendation and has amended the regulation to reflect requirements that only current test instruments be used in the evaluation process, and that test results be scored and reported accordingly.

Section 69-4.10

Site where services are delivered

COMMENT: Nine commenters opposed changes related to permissible locations for group early intervention services delivered to children in the EIP.

RESPONSE: Agreements between the Department and EI providers require that providers document the location(s) where they will provide EI services in the provider's current DOH approval. This requirement is essential to ensure that locations where services are provided to young children are known to the Department for monitoring purposes. Additionally, including the provider's site(s) of operation in the Agreement provides evidence of how such sites meet the Department's health and safety standards, as outlined in regulations, the provider agreement, and guidance memoranda. Specifying the site where services will be delivered helps to ensure that providers can be mandated to remediate health and safety violations that impact the safe delivery of EI services.

The proposed regulations continue to provide for group services to be delivered at approved EI provider sites which are also licensed day care facilities in the community. Any community-based sites where EI services will occur must be included in the provider's application for Department approval. Additional community-based sites the provider proposes to use above those already included in the approved Agreement a provider has on file with the Department must be submitted to the Department's Provider Approval Unit as an amendment request.

COMMENT: One commenter recommended that "licensed" be added before "community-based site" for parent-child groups, and that the site of service delivery be clearly listed on the IFSP with the provider's name and contact information.

RESPONSE: As agency licensure is already an implied requirement for the operation of community-based service sites, changes to the regulation are not necessary in response to this comment.

Notification of the CPSE

COMMENT: One commenter noted that parents with limited functional abilities or limited resources should be able to object orally to the notification of the committee on preschool special education of their child's potential transition.

RESPONSE: The requirement that the parent object in writing, not orally, to written notification of the Committee on Preschool Special Education (CPSE) of their child's potential transition aligns with requirements of the U.S. Department of Education, Office of Special Education Programs (OSEP); this amendment was made at the request of OSEP. EI service coordinators can assist parents to fulfill this requirement as necessary as part of transition

planning.

Section 69-4.11

Frequency of services

COMMENT: Two commenters opposed requiring the frequency of EI services included in an IFSP to be specified on a weekly basis, versus over a longer (monthly or six-month) period; another commenter questioned whether the "per week" requirement would preclude the provision of services on a less frequent basis.

RESPONSE: The EIP is a family-centered program. This modification is necessary to improve consistency across individualized family service plans (IFSPs) to ensure that parents and caregivers know what to expect regarding delivery of EI services on a regular basis and can plan accordingly. In cases where certain services are delivered less often than weekly, the IFSP must specify when the service will be delivered – for example, every other week, or every four weeks, or the first week of each month – so that it is clear when and how often the service will be provided. This will ensure that EI services are delivered to children and families as agreed upon in the IFSP and in accordance with written orders as applicable, facilitate monitoring of EI service delivery, and facilitate the Department's ability to address system complaints when disputes arise.

Section 69-4.26
Documentation requirements

Written orders

COMMENT: Two commenters opposed requiring written orders for evaluations where such orders are required, citing concern over meeting the required 45-day timeline from evaluation to development of the child's IFSP.

RESPONSE: The EIP serves infants and toddlers with developmental delays or disabilities, ages birth to three years. Certain practitioners are required under their practice acts to have a written order to conduct an evaluation; additionally, written orders are required for various practitioners by payors including the Medicaid program. Obtaining a written order from the child's primary care provider at the time of referral to the EIP ensures that the child's medical provider is aware that the child is undergoing an evaluation to determine eligibility for EI services and affords an opportunity for the medical provider to have input in the ongoing care of the child. Additionally, engaging the primary medical care provider earlier in the process can facilitate obtaining written orders for those services requiring such orders for children found eligible for EI services.

Service logs

COMMENT: Five commenters opposed having the parent sign a service log to verify that EI services were received by the child, citing concerns about child and family outcomes/timely communication with the family, due process, health and safety, and fraud prevention.

RESPONSE: Existing EI regulations at 10 NYCRR section 59-6.26(c) require providers to have parent signatures on a service log (not the session note). Specifically, the service log must document that the service was received by the child on the date and during the period of time recorded by the service provider. Requiring the provider to have the parent sign the session note would likely result in the provider writing the session note during therapy time, which is not permissible. For example, if a 45-minute session is included in the child's IFSP, then 45 minutes of direct service to the child and family must be delivered. A provider's administrative responsibilities fall outside that window.

How to specify group size

COMMENT: One commenter recommended additional clarification on recording of group size in providers' session notes to ensure that the actual group size, not the size of the approved group, is recorded.

RESPONSE: The Department agrees with this recommendation and has amended the regulation to stipulate that session notes should record the actual size of a participating group.

Content of session notes

COMMENT: Several commenters supported the addition of "the date the session note was created" to documentation requirements under the EIP; one commenter questioned the rationale for adding "the date the session note was created" to documentation requirements.

RESPONSE: EI providers must ensure that all required documentation is in place prior to submitting claims for EI services furnished to eligible children and their families. Documentation is to be completed contemporaneously, or as close to the conclusion of the session as practicable, and in advance of submitting a claim, which occurs within 90 days of the date of service. In some circumstances, the practitioner furnishing the service is under the direction of, or under the supervision of, another qualified provider, which means that both providers must sign/date the session note. Inclusion of these dates will help to ensure timely documentation and, where required, that the directing/supervising provider has reviewed the notes on a timely basis.

Section 69-4.30

Reimbursement

Multidisciplinary evaluation

COMMENT: Two commenters supported elimination of the concept of a core evaluation in the context of multidisciplinary evaluations; some commenters opposed this change, expressing

concern regarding this modification in connection with developing an appropriate IFSP and in connection with securing audiological evaluations.

RESPONSE: Multidisciplinary evaluations (MDEs) are furnished for the purpose of determining eligibility for the EIP for children who are suspected of having a developmental delay and also help to establish baselines for intervention for children who are found eligible for EI services. As such, it is expected that one comprehensive MDE will be delivered to identify the child's needs in five (5) developmental domains for the purpose of determining a child's eligibility for the EIP, and one claim will be submitted for the comprehensive MDE.

Based on the intake information from parents/caregivers, the MDE must include evaluators possessing expertise to address the presenting concerns about the child. In accordance with federal requirements at 34 CFR Part 303.321, and state regulations, one component of the MDE is to identify the child's needs in five (5) developmental domains – cognitive, physical (including vision, hearing and oral motor feeding and swallowing disorders), communication, social-emotional, and adaptive – in accordance with 10 NYCRR section 69-4.8(f)(3). Given the comprehensive nature of the MDE, supplemental evaluations are not to be conducted concurrently with the MDE. As noted, one claim is to be submitted for the MDE. Upon determining eligibility through a comprehensive MDE, the initial IFSP is developed. The IFSP can be modified either at the six-month review or at a different (more frequent) interval at the request of the parent or provider if additional concerns emerge or progress is not as expected.

COMMENT: One commenter opposed eliminating supplemental audiological evaluations prior to the development of an IFSP.

RESPONSE: The proposed regulations include accommodations specific to audiological evaluations. To determine whether hearing loss is present, the proposed regulations provide that a supplemental audiological evaluation may take place prior to an IFSP for infants who do not pass their newborn hearing screening and/or who are at risk of hearing loss.

Establish minimum number of minutes for billable (basic) session

COMMENT: One commenter requested clarification of the proposed minimum time of 30 minutes for basic home/community and office/facility-based EI individual visits.

RESPONSE: Under existing regulations, no minimum length of time for basic visits is established. The proposed regulations provide that basic EI visits will be 30-59 minutes in duration and extended visits will continue to be 60 or more minutes in duration. This change to section 69-4.30(c)(5)(i) will ensure that all basic EI service visits are a minimum of 30 minutes in length before they are billable. This change was made in accordance with direction from the Centers for Medicare and Medicaid Services (CMS) during the review of Medicaid State Plan amendment #18-0039 (EI Early and Periodic Screening, Diagnostic and Treatment – EPSDT – services).

COMMENT: Several commenters recommended clarification to ensure collateral services are provided in the context of the family.

RESPONSE: The Department agrees with this recommendation and has amended the language to clarify that collateral services should be provided in the participant's family environment.

Group early intervention service visit

Site where services are delivered

COMMENT: Nine commenters opposed changes related to permissible locations for group early intervention services delivered to children in the EIP.

RESPONSE: Agreements between the Department and EI providers require that providers document the location(s) where they will provide EI services in the provider's current DOH approval. This requirement is essential to ensure that locations where services are provided to young children are known to the Department for monitoring purposes. Additionally, including the provider's site(s) of operation in the Agreement provides evidence of how such sites meet the Department's health and safety standards, as outlined in regulations, the provider agreement, and guidance memoranda. Specifying the site where services will be delivered helps to ensure that providers can be mandated to remediate health and safety violations that impact the safe delivery of EI services. The proposed regulations provide for group services to be delivered at approved EI provider sites which are also licensed day care facilities in the community.

Eliminate basic and enhanced groups as related to group composition

COMMENT: Several commenters opposed eliminating the basic and enhanced group constructs to effectuate a single early intervention (EI) group service and opposed reducing EI group sizes from a maximum of 12 children to a maximum of 8 children.

RESPONSE: The *basic* group developmental service construct was included in EI policy guidance titled *Early Intervention Program: Group Developmental Intervention Services Standards* issued in November 2013. The basic group construct was intended to accommodate children with less intense needs, with a ratio of one (1) staff for every four (4) children. The recommended number of children in the basic group was eight and should not exceed 12 at any

time. The *enhanced* group was intended to accommodate children with more intense needs, with a ratio of 1 staff for every three children, and recommended up to six (6) children, not to exceed 12 eligible children to one EI provider and three aides/assistants at any time. However, it is clear from the comments received regarding group size and from the Department's review of early intervention (EI) data that these distinctions are generally not implemented in practice.

The Department proposed and clarified the definition of group services as EI early intervention services delivered to two (2) to eight (8) children in the EIP. A one-to-one aide may be included in the IFSP of a child receiving group EI services, based on clinical appropriateness, to support the child's participation in the group EI service. Given capacity concerns expressed and the issue of absenteeism noted by commenters, the maximum group size will be adjusted to ten (10) for toddler groups receiving EI services.

Group size

COMMENT: Several commenters firmly opposed limiting the maximum size of an early intervention group to eight (8) children, from previous policy guidance permitting up to 12 toddlers in a group, citing financial concerns or potential capacity issues. One commenter cited staffing ratios found in New York City day care regulations (Article 47, section 47.23) as more appropriate for delivery of EI services to toddlers in a group setting.

RESPONSE: The EIP serves infants and toddlers with developmental delays or disabilities and differs from supervision of children in a day care setting. An analysis of group EI services furnished in 2022 showed that 95% of groups consisted of 10 children or fewer. Therefore, the regulations have been amended to allow for a maximum group size of ten (10) young children. This better aligns with ratios for special education services and recognizes absenteeism concerns.

Staffing of groups

COMMENT: A commenter expressed concern that staffing of a group of toddlers would be unsafe with only two adults, noting that it would not be feasible to support children who are non-ambulatory or with behavioral issues safely.

RESPONSE: The proposed regulations provide that groups shall be provided by, at a minimum, one approved and appropriately qualified early intervention provider and one assistant, and further provide that a one-to-one aide, based on clinical appropriateness, can be included in the IFSP of a child who will receive group EI services. Therefore, if a child with a group EI service recommended on their IFSP has a clinical need for more direct (1:1) care, the child may have a one-to-one aide included in their IFSP to facilitate participation in the group.

Rates for group services

COMMENT: A commenter requested that the group rate remain at the rate that has been in place for enhanced group services.

RESPONSE: The Department will take this comment under advisement. No changes to the regulation are being made as a result of this comment.

Composition of groups

COMMENT: Commenters expressed concern about grouping children with similar 'disabilities' versus similar needs/composition of groups based on IFSP outcomes.

RESPONSE: The intent of providing group early intervention services to children with similar IFSP outcomes is to encourage use of group services when appropriate to foster development of

speech-language skills, motor skills, learning, and the like. Children with different diagnoses in in the birth to three-year-old age range are likely to have similar communication or learning goals and can participate in the same or similar activities in a group setting. There is no intent to group children by "disabilities," but rather to leverage experts in various clinical disciplines in the provision of group EI services. Furnishing group EI services led by clinicians with expertise in disciplines such as speech-language, special instruction, physical or occupational therapy, where appropriate, may also help to mitigate capacity issues.

Preventing Duplication of Services

COMMENT: Eight commenters opposed removing push in/pull out services during the delivery of group EI services, citing challenges in transportation if two services cannot be delivered at the same time, and noting that facility-based services are sometimes the only option in low-income communities. Commenters also suggested that that longer group session times are necessary to implement this model.

RESPONSE: The practice of seeking reimbursement for delivery of both a group EI service and an individual therapy service at the same time is not allowable under the EIP. Recommending services in a group setting means that the toddler is intended to benefit from the therapeutic intervention and the interaction within the group. Further, a child requiring additional assistance to participate successfully in the group may continue to have a one-to-one aide included in his or her IFSP.

An individually delivered service (either having the therapist come to the group ("push in") or having the child removed from the group ("pull out")) included in the IFSP for the purpose of providing a one-to-one therapeutic intervention is not separately billable while the child is

scheduled to be participating in the group service included in his or her IFSP. If such an individual service is recommended in the IFSP, it must take place as a separate, stand-alone service to be billable.

Duration of group EI service

COMMENT: Some commenters noted that 60-minute minimum time for group sessions might result in billing for back-to-back group sessions, or a so-called "2-group" model.

RESPONSE: Billing for back-to-back group sessions for the same children/same discipline is prohibited. A 2-hour group session for the same children receiving the same service is a single session and must be billed accordingly. However, if two 1-hour groups occur in a row (back-to-back) with different students or with a different discipline (e.g., speech-language group led by a speech-language pathologist for the first hour and a different group service such as special instruction led by a special educator during the next hour), billing for each 1-hour group session would be permissible. Providing EI services in this way, where appropriate to meet children's IFSP outcomes, has the potential to improve capacity for delivery of EI services.

Applied Behavior Analysis (ABA) – basic or extended

COMMENT: Some commenters expressed concern that applied behavior analysis services would be billed in 30-minute increments instead of 60-minute increments.

RESPONSE: The existing billing of a minimum of 60 minutes for applied behavior analysis (ABA) services assumes that all ABA services are furnished in extended sessions. The proposed regulations provide that individual ABA services can be billed using the current EI billing categories of basic and extended visits, which are used for all other general EI individual services. Any individual service lasting 60 minutes or more is billed as an extended service;

services under 60 minutes are to be billed as basic visits. Billing of back-to-back basic or back-to-back extended visits furnished by the same therapist to the same child is prohibited.