townhall.virginia.gov

Final Regulation
Agency Background Document

Agency name	Department of Behavioral Health and Developmental Services
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC35-105
VAC Chapter title(s)	Rules and Regulations For Licensing Providers by the Department of Behavioral Health and Developmental Services
Action title	Allowing a grace period for documentation of ISPs
Date this document prepared	July 16, 2020 UPDATED 1/13/21

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This regulatory action to amend Chapter 105 ("Licensing Regulations") pertains to when a quarterly review of an individualized services plan (ISP) must be documented. It is intended to resolve misalignment between DBHDS and DMAS regulations concerning the documentation of quarterly reviews of ISPs by allowing practitioners to follow the same process rather than two different processes. For example, in DMAS regulation 12VAC30-50-226 Community mental health services, the definition of "Review of ISP" contains a corresponding 15-day grace period. Also, a grace period has existed since at least 1998 in 12VAC30-60-143 (previously subsection 140) Community mental health services.

These amendments will relieve an unnecessary administrative burden in which service providers currently must adhere to two separate regulations for the same practice. The current Licensing Regulations will be amended as follows*:

12VAC35-105-675. Reassessments and ISP reviews.

A. Reassessments shall be completed at least annually and when there is a need based on the medical, psychiatric, or behavioral status of the individual.

B. The provider shall: (i) update the ISP at least annually; and . ~~The provider shall~~ (ii) complete quarterly ~~review~~ reviews of the ISP. The provider shall review the ISP at least every three months from the date of the implementation of the comprehensive ISP ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~. These reviews shall evaluate the individual's progress toward meeting the ~~plan's~~ ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.

***Note:** UPDATE It is relevant in reviewing this action to be aware of the changes to Section 675 in Regulatory Action 5040, and in general to see sections 645 – 665 for Chapter 105 for a broader view of language related to ISPs. This action became effective on August 1, 2020; therefore, the changes listed above are now placed in the current regulatory text in the final stage:

A. Reassessments shall be completed at least annually and any time there is a need based on changes in the medical, psychiatric, behavioral, or other status of the individual.

B. Providers shall complete changes to the ISP as a result of the assessments.

C. The provider shall update the ISP at least annually and any time assessments identify risks, injuries, needs, or a change in status of the individual.

D. The provider shall complete quarterly ~~review~~ reviews of the ISP at least every three months from the date of the implementation of the comprehensive ISP ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~.

1. These reviews shall evaluate the individual's progress toward meeting the ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made.
2. These reviews shall document evidence of progression toward or achievement of a specific targeted outcome for each goal and objective.
3. For goals and objectives that were not accomplished by the identified target date, the provider and any appropriate treatment team members shall meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.

***Note:** The DBHDS regulatory action 5091 filed on July 16, 2018, received 10 comments from CSBs during the public comment period that ended on March 6, 2019. The comments related to the need to separate case management from the 15-day language.

***Note:** The State Board of BHDS subsequently concurred with staff's recommendation to shift to the standard regulatory process. This occurred on March 14, 2019. The State Board voted on the revised language for the standard process on July 17, 2019, and confirmed the same language for the final stage on July 15, 2020. The fast track action now counts as the NOIRA for this standard action.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

CSBs – Community services boards.
DBHDS – Department of Behavioral Health and Developmental Services.
DMAS – Department of Medical Assistance Services.
ISP – Individualized services plan.
State Board – State Board of Behavioral Health and Developmental Services.

Statement of Final Agency Action

Provide a statement of the final action taken by the agency including: 1) the date the action was taken; 2) the name of the agency taking the action; and 3) the title of the regulation.

The State Board voted on July 15, 2020, to initiate the final stage of the action titled 'Allowing a grace period for documentation of ISPs' to amend the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services [12 VAC35-105], with no change stage of the language from the proposed stage to final stage.

Mandate and Impetus

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding the mandate for this regulatory change, and any other impetus that specifically prompted its initiation. If there are no changes to previously reported information, include a specific statement to that effect.

There is no mandate for this regulatory action. It came at the request of community services boards (CSBs) through the Virginia Association of Community Services Boards (VACSB) in April 2018.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Section 37.2-203 of the Code of Virginia authorize the State Board to adopt regulations that may be necessary to carry out the provisions of Title 37.2 and other laws of the Commonwealth administered by the commissioner and the department. This permanent action was approved at the July 17, 2019, meeting of the State Board.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

DBHDS and DMAS regulations concerning reviews of individual service plans are not aligned. This creates an unnecessary situation in which service providers must adhere to two separate regulations for the same practice. The proposed change will align DBHDS and DMAS regulations as to when the quarterly review of the ISP must be documented, thus allowing practitioners to follow the same process rather than two different processes. This will decrease administrative burdens and allow more time to provide services.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

Providers licensed by DBHDS are currently required to review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. There is no allowance for additional administrative time to document the review, as is allowed in DMAS regulations. Such administrative 'grace periods' are not uncommon.

By amending the current Licensing Regulations at the end of Subsection B of 12VAC35-105-675 through this action, providers will be allowed to provide documentation of each quarterly review or a revised assessment in the individual's record '*no later than 15 calendar days from the date the review was due to be completed*.' These amendments will not change the current quarterly deadline for the review. Also, clarification is made to exclude case management from this 15-day change, and specific language is added regarding 30 days related to case management. This was in response to comments received, as listed below.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

There are no identified disadvantages to the public or the Commonwealth in making this change. The advantage for the system will be that providers have more efficient use of time because the regulations will no longer be duplicative in conflicting ways.

Requirements More Restrictive than Federal

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any requirement of the regulatory change which is more restrictive than applicable federal requirements. If there are no changes to previously reported information, include a specific statement to that effect.

This requirement is no more restrictive than applicable federal standards.

Agencies, Localities, and Other Entities Particularly Affected

List all changes to the information reported on the Agency Background Document submitted for the previous stage regarding any other state agencies, localities, or other entities that are particularly affected by the regulatory change. If there are no changes to previously reported information, include a specific statement to that effect.

No agency, locality, or entity is particularly affected.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

Seventeen comments were received during the 60-day public comment period held during the proposed stage (1/20/20 – 3/20/20). There was overwhelming support for the action.

Commenter	Comment	Agency response
Dr. Alexander Moore	I am in favor of an extension of the quarterly review inorder to get three whole months documented and get signatures from parents , AR , guardians and get the documentation into a chart whether in electronic record keeping chart or the individual binder. I am not sure of how much time is being proposed but please allow for an extension of time that allows for the entire process to take place in a manner that does not have conflicts in delivery of a 3 month time frame.	Thank you for your comment in support of this regulatory action. The proposed action would allow providers to document the quarterly review no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due.
Susie Q	Over the last 5 -7 years there has been a shift in community mental health. Particularly in the last 6 months the shift for private providers dealing with not only DBHDS and DMAS regulations but also now MCO (managed care organizations) regulations has become the biggest administrative burden. While this town hall comment is not necessarily here for that topic it sets the stage for politicians to understand the climate of community behavioral health right now. The focus from true care to worrying about	Thank you for your comment. The regulatory requirement for providers to conduct quarterly reviews every 90 days ensures that all providers across the Commonwealth evaluate the individual's progress toward meeting the ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The proposed regulatory action is intended to resolve misalignment between DBHDS and DMAS regulations concerning the documentation of quarterly reviews of ISPs by allowing practitioners to follow the same process rather than two different processes. For

	paperwork constantly for 3 (4 if you count human rights) different types of regulatory entities takes so much away from actually helping people. There should absolutely be regulations and rules to follow so that private providers like myself can follow ethical guidelines and demonstrate quality care. However, when the focus shifts from the client and what they need to meeting a deadline all the time it is very burdensome. ISP's should be revised. I tell my staff they are a working document. The burden of counting out exactly 90 days for a review and then ensure whether it snows, hails, sleets, etc we see them on the 90th day to get a signature and finalize review is really not therapeutic at all. If the focus was on the actual ISP and reviewing it as needs changed or even allowing for the administrative time to review it and obtain signatures around the 90 day period (maybe a 30 day grace period) then it may become a more useful document. There is no point in an ISP every 90 days when people are just doing it to do it and say it was done. If we had more flexibility as the provider to have more time to revise it, review it, and obtain signatures within a grace period than the quality of care I believe would increase. Now the only downfall to all of those thoughts are that the MCO's now want the ISP to accompany the Service Authorization request. Those requests go in every 90 days so you may run into issues if the ISP has not been revised in time. Overall, it sucks that all 4 entities plus MCO's are not on the same page at all about regulations that are in black and white and those that we are trying to serve are greatly affected by it. People being denied for services left and right because they have had them for "too long" or "the service failed"...	example, in DMAS regulation 12VAC30-50-226 Community mental health services, the definition of “Review of ISP” contains a corresponding 15-day grace period. Also, a grace period has existed since at least 1998 in 12VAC30-60-143 (previously subsection 140) Community mental health services. By amending the current Licensing Regulations at the end of Subsection B of 12VAC35-105-675 through this action, providers will be allowed to provide documentation of each quarterly review or a revised assessment in the individual’s record ‘no later than 15 calendar days from the date the review was due to be completed.’ These amendments will not change the current quarterly deadline for the review. Also, clarification is made to exclude case management from this 15-day change, and specific language is added regarding 30 days related to case management. This was in response to comments received from the public during a previous stage of the regulatory process.

	after 18 months. I have so many "stories" that are real clients lives that are being affected by these ridiculous decisions. Big money companies are just trying to save the government money. I envision within a few years we will be back like the settlement days with mentally ill individuals walking the streets and homeless. That is the direction we are headed. So while I applaud the opportunity to correct an administrative time crunch there are some really big issues at stake in our community behavioral health world.	
(No commenter name)	I am fully in agreement to allow a grace period for completing the quarterly review. Working in an OTP, the development of the treatment Plan (ISP) can be very time consuming, The process of reviewing the treatment plan with the patient, making changes to the treatment plan if necessary and obtaining signatures is not a simple process. In our population patients can be seen any where from daily to monthly depending on how long they have been in treatment. It is impossible to ensure that the review is completed by the specific date, especially if the patient is not at the program on the deadline. Writing the treatment plan is also time consuming and counselors have often found there self writing the treatment plan with the patient in the office, which leaves the patients sitting there while the counselor is typing out the treatment plan and is not productive at all for the patient. What normally ends up happening is the treatment plan is brushed over and hurried. It is a constant juggle between meeting the patients needs and completing the paperwork that is required. Although not specifically addressed here, I feel compelled to address the DMAS requirement	Thank you for your comment in support of this regulatory action.

	for an IPOC (ISP) on top of the required treatment plan that we currently are required to do, It is tedious and repetitive and adds an extra burden on both the counselor and the patient. Why are these patients required to have essentially two treatment plans (ISP) because they are on Medicaid.	
John Malone	I am in favor of the proposed grace periods	Thank you for your comment in support of this regulatory action.
(No commenter name)	Support Coordinators in Hanover are in agreement with the proposed changes. Many providers provide more than one service to an individual served (community engagement, day support, residential) and have to complete more than one quarterly per person every 90 days. This would allow the provider more time to complete the required documentation. Keeping the grace period of 30 days for the Support Coordinator to complete the quarterly is much appreciated. We have a process to track down quarterlies from providers who don't send them in a timely manner and we inform DBHDS Community Resource Consultant of providers who don't send their quarterlies within the time period. Our only concern would be that even with an extension from 10 to 15 days for the provider, there will continue to be providers who don't send their quarterlies to the Support Coordinator and there is little to no consequence for it.	Thank you for your comment in support of this regulatory action. The proposed action would allow providers to document the quarterly review no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due. Under the proposed action, non-case management providers who fail to document the quarterly review within 15 calendar days from the date the review was due to be completed, would be out of compliance with the Licensing Regulations and may be cited accordingly.
(No commenter name)	AHCS is in favor of the quarterly extensions.	Thank you for your comment in support of this regulatory action.
Steve Stewart	We are in full agreement with the proposed changes and feel they	Thank you for your comment in support of this regulatory action.

	will benefit CSB's and providers by allowing sufficient time to compile information and complete accurate and comprehensive reviews.	
Rinda Theibert	please just get the CSB case workers/ support coordinators to do their jobs in a timely manner and stop delaying everything for no reason... their jobs are not difficult and the amount of paperwork they have to do is min. (special education teachers for example have much more paperwork in a similar type of job) … I wish these gatekeepers weren't even part of the process to access services for people with DD... how much time do they really need to type a few paragraphs into a program ?	Thank you for your comment. The proposed regulatory action is intended to resolve misalignment between DBHDS and DMAS regulations concerning the documentation of quarterly reviews of ISPs by allowing practitioners to follow the same process rather than two different processes. For example, in DMAS regulation 12VAC30-50-226 Community mental health services, the definition of "Review of ISP" contains a corresponding 15-day grace period. Also, a grace period has existed since at least 1998 in 12VAC30-60-143 (previously subsection 140) Community mental health services. By amending the current Licensing Regulations at the end of Subsection B of 12VAC35-105-675 through this action, providers will be allowed to provide documentation of each quarterly review or a revised assessment in the individual's record 'no later than 15 calendar days from the date the review was due to be completed.' These amendments will not change the current quarterly deadline for the review. Also, clarification is made to exclude case management from this 15-day change, and specific language is added regarding 30 days related to case management. This was in response to comments received from the public during a previous stage of the regulatory process.
Rinda Theibert	there is no reason to burden private providers with CSB case workers and MCO program... it was so much easier and therapy whatever so much more effective when people could just help the person seeking treatment and not jump through all these unneeded extra hoops... things were so much better before Medicaid was taken over by all these MCO programs	Thank you for your comment.
Ken Crum	We are in agreement with the proposed changes and feel they will benefit CSB's and providers by allowing sufficient time to compile	Thank you for your comment in support of this regulatory action.

	information and complete accurate and comprehensive reviews. As a provider, we appreciate this action by DBHDS to ease one of the required documentation processes.	
concerned citizen	I know one of their group homes run by kemetic behavioral health norfolk va clients is a ward of Jewish Family Services. they only have one small group home. It would be interesting to know if Jewish Family Services is doing a poor job of acting as client and not signing documents in timely manner. It is very sad the way the system works and takes loved ones away from family and friends then takes the consumers small SSI check to pay for guardianship services (at least the rep payee part) From our understanding a local city is paying them for the rest of the guardianship part. It is even more upsetting a paid agency is doing a poorer job then a private guardian would be allowed to do. Maybe that is more of a problem. Maybe giving agencies more time to deal with government paid guardians isn't the answer; maybe letting people have people who give a crap control their lives would be a better idea. Isn't that what the Olmstead Settlement was supposed to be about?	Thank you for your comment. This comment falls outside of the scope of the proposed regulatory action.
(No commenter name)	I agree that the grace period should be extended. With the new CMS requirements, that require time to address, it would be beneficial if providers were afforded the opportunity to have an extended period of time to document reviews or any other regulatory requirement.	Thank you for your comment in support of this regulatory action.
Kimberly Jones	We agree with this extension of the grace period. We provide services to many individuals that require quarterlies, sometimes one person is working on up to 25 a month on top of other job duties. Having that extra time will also really help	Thank you for your comment in support of this regulatory action.

	when the 10 days is also decreased by weekend and some holidays.	
Tamara Starnes	Supportive and appreciative of the proposed grace period for quartiles.	Thank you for your comment in support of this regulatory action.
Carol McCarthy	I am in support of the grace period for quarterly reviews and the alignment of DBHDS/DMAS Regulations.	Thank you for your comment in support of this regulatory action.
Keonna Mack	In agreement with adding a grace period for Quarterly/Person Centered Reviews.	Thank you for your comment in support of this regulatory action.
(No commenter name)	We are in favor of the proposed grace period for the submission of quarterly reviews. This will allow for easier scheduling, review of plans and to make any requested changes with regard to the individuals, case management and guardians/family members. This also provides a cushion in case of an emergency situation due to injury, illness, weather or natural disaster.	Thank you for your comment in support of this regulatory action.

Detail of Changes Made Since the Previous Stage

*List all changes made to the text since the previous stage was published in the Virginia Register of Regulations and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

No changes were made since the proposed stage.

Detail of All Changes Proposed in this Regulatory Action

*List all changes proposed in this action and the rationale for the changes. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. * Put an asterisk next to any substantive changes.*

UPDATED with current language since regulatory action effective August 1, 2020.

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
675 B		A. Reassessments shall be completed at least annually and any time there is a need based on changes in the medical, psychiatric, behavioral, or other status of the individual. B. Providers shall complete changes to the ISP as a result of the assessments. C. The provider shall update the ISP at least annually and any time assessments identify risks, injuries, needs, or a change in status of the individual. D. The provider shall review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. 1. These reviews shall evaluate the individual's progress toward meeting the ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. 2. These reviews shall document evidence of progression toward or achievement of a specific targeted outcome for each goal and objective. 3. For goals and objectives that were not accomplished by the identified target date, the provider and any appropriate treatment team members shall meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed.	Proposed Changes: A. Reassessments shall be completed at least annually and any time there is a need based on changes in the medical, psychiatric, behavioral, or other status of the individual. B. Providers shall complete changes to the ISP as a result of the assessments. C. The provider shall update the ISP at least annually and any time assessments identify risks, injuries, needs, or a change in status of the individual. D. The provider shall complete quarterly review reviews of the ISP at least every three months from the date of the implementation of the comprehensive ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. 1. These reviews shall evaluate the individual's progress toward meeting the ISP's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. 2. These reviews shall document evidence of progression toward or achievement of a specific targeted outcome for each goal and objective. 3. For goals and objectives that were not accomplished by the identified target date, the provider and any appropriate treatment team members shall meet to review the reasons for lack of progress and provide the individual an opportunity to make an informed choice of how to proceed. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly

			reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due. Intent, rationale, and likely impact: Per DMAS guidelines, the case manager/support coordinator (SC) is permitted a 30-day grace period to complete the person-centered review (quarterly). This is critically important for SCs to meet the expectations for oversight of services as indicated in the Settlement Agreement. Other providers of direct services will be allowed a 15-day grace period to complete quarterly reviews. The changes are intended to resolve misalignment between DBHDS and DMAS regulations concerning quarterly reviews of ISPs, or a revised assessment, by allowing practitioners to follow the same process rather than two different processes, yet allowing for the requirements related to the Settlement Agreement. This phrase is redundant: ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~.

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
675 B		B. The provider shall update the ISP at least annually. The provider shall review the ISP at least every three months from the date of the implementation of the ISP or whenever there is a revised assessment based upon the individual's changing needs or goals. These reviews shall evaluate the individual's progress toward meeting the plan's goals and objectives and the continued relevance of the ISP's objectives and strategies. The provider shall update the goals, objectives, and	Proposed Changes: B. The provider shall: (i) update the ISP at least annually; ~~. The provider shall~~ (ii) complete quarterly ~~review~~ reviews of the ISP. The provider shall review the ISP at least every three months from the date of the implementation of the comprehensive ISP ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~. These reviews shall evaluate the individual's progress toward meeting the ~~plan's~~ ISP's goals and objectives and the continued relevance of the

		strategies contained in the ISP, if indicated, and implement any updates made.	ISP's objectives and strategies. The provider shall update the goals, objectives, and strategies contained in the ISP, if indicated, and implement any updates made. Documentation of the quarterly review shall be added to the individual's record no later than 15 calendar days from the date the review was due to be completed, with the exception of case management services. Case management quarterly reviews shall be added to the individual's record no later than 30 calendar days from the date the review was due. Intent, rationale, and likely impact: Per DMAS guidelines, the case manager/support coordinator (SC) is permitted a 30-day grace period to complete the person-centered review (quarterly). This is critically important for SCs to meet the expectations for oversight of services as indicated in the Settlement Agreement. Other providers of direct services will be allowed a 15-day grace period to complete quarterly reviews. The changes are intended to resolve misalignment between DBHDS and DMAS regulations concerning quarterly reviews of ISPs, or a revised assessment, by allowing practitioners to follow the same process rather than two different processes, yet allowing for the requirements related to the Settlement Agreement. This phrase is redundant: ~~or whenever there is a revised assessment based upon the individual's changing needs or goals~~.