212-RICR-10-10-1 (BHO)

Response to Public Comments

The following are responses to public comments on the proposed regulations for Behavioral Health Organizations (BHO) from the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals. The comments are arranged by general topic areas. Many of the comments received on the proposed BHO regulations merit further review and discussion with stakeholders but constitute substantive changes, triggering additional period of public outreach which would not be possible prior to December 31, 2018. To that end, the Department will reconvene the stakeholder groups in 2019 and will entertain recommendations for amendments at that time.

Training and Supervision

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
#6BH Comment ID: #10211-22 Ruby Nicholson Thrive Behavioral Health (Thrive)	1.5.4 D, 1.5.4 F	Extensive training is available for staff in DD systems of care in behavior management, not so in CBHOs. Clarify how behavior management training is defined.	Will Department provide training opportunities? Will in-house training be adequate or is more in-depth training required?	Language will remain the same.	The Department will explore opportunities to expand training opportunities that can serve the needs of BHOs. There is a currently approved curriculum that meets this standard.
#6BH Comment ID: #10211-22 Ruby Nicholson Thrive	1.6 B.3, 1.6 B.4	Define preference in “Preference for a minimum of 4 hours of clinical supervision”. Is 4 full hours required? This section counts hours more than addresses clinical competencies.	Section be rewritten to focus more on what needs to be included in documented, on-going supervision. Potential content areas: ethical decision making, cultural competencies, motivational interviewing, recovery principles, professional	Language will remain the same.	This section of the regulation sets out minimum standards for a supervisor and minimum number of hours of supervision based on licensure status of the staff members. Section 9 In the prior version of the BHO regulations did not mandate specific content area to be covered in supervision. This provides flexibility to address the most

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			standards, staff performance, etc.		pressing and important needs of the employee and supervisor.
#6BH Comment ID: #10211-22 Ruby Nicholson Thrive	1.6.10 2.a	What is considered “appropriate training to supported employment and substance use”?	Is this specific training or can this be provided by a supervisor during orientation or at a team meeting?	Language will be revised to reflect this non-substantive change.	Language will be revised as follows: Supervisors will identify appropriate training to assure clinical competency in supported employment and substance use for staff providing case management services. Staff will be provided opportunities to participate in training opportunities identified.

Licensing & Accreditation

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
#5BH Comment ID #10211-20 Lisa Rafferty Keystone	NA	Numerous – see comment.	Numerous – see comment.	Comments are not directly relevant BHOs and better suited to response associated with 212-RICR-10-00-01.	Responses to public comment are contained in the summary for 212-RICR-10-00-01.
#10BH Annajane Yolken Substance Abuse and Overdose Preventio	NA	Numerous – see comment.	Numerous – see comment.	Comments are not directly relevant BHOs and better suited to response associated with 212-RICR-10-00-01.	Responses to public comment are contained in the summary for 212-RICR-10-00-01.

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
n PAC Rhode Island					
#7BH Comment ID: #10211-25 Wendy Looker OTARI	1.4.2 C.1.E, 1.4.2 C.1.F	Accreditation requires culture and diversity plan. Does this suffice for these regulations?		Where the standards of the accrediting body meet or exceed what is required by the regulations, the Department will deem.	Where the standards of the accrediting body meet or exceed what is required by the regulations, the Department will deem.
#9BH Comment ID: #10211-14 Cynthia Wheeler Newport County Mental Health (Newport)	1.6.11 B.4	SUD specialist (BA level) requirement does not match LCDP licensure.		Language will remain the same.	The language referenced is specific to IHH/ACT services and reflects the staffing pattern as described in the Medicaid State Plan Amendment and is consistent with the manual. It is not inconsistent with federal law. The Department's expectation is that in the absence of holding a current license at the LCDP level or higher, the individual providing these services should have both a bachelor's level degree AND experience working with individuals with substance use disorders AND be working towards credentialing and licensure.
#3BH Comment	Unspecified	Are BHOs required to be accredited by JCAHO or		See response.	BHOs are not required to be accredited.

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
ID: #10211-12 Lynn Costigan-Serra		CARF?			
#7BH Comment ID: #10211-25 Wendy Looker OTARI	Unspecified	Bulk of regulations are appropriate for DD and/or residential population, not appropriate for outpatient and especially opioid treatment programs. At licensing audits, are they required to meet regs that are not applicable to outpatient settings? If not required to meet regs, how is this determined, and would this be included in the promulgation of new regulations to ensure protection from being cited?		Language will remain the same. If there are specific recommendations for revision they will be entertained in 2019.	The General Licensing regulations apply to all licensed entities. It is not clear what the concern is referencing.

Factual or Language Corrections

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
#11BH; #12BH; #13BH; The Providence Center (TPC)	1.3.14	Definition of CMHC/CMHO is focused on an organization that delivers services “within a specific geographic area”	Nothing in statute restricts CMHOs from providing beyond their service area	Language will remain the same.	The definition provided does not restrict a CMHC/CMHO from providing beyond their service area. See § 40.1-8.5-2 (10) which defines service area as geographically based.
#8BH	1.6.14 A.2,	Revise outdated	Term should be “FDA	Language will be	Language will be

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
Comment ID: #10211-26 Susan Storti SUMHLC	1.6.14 A.3, 1.6.14 A.16.a, 1.6.14 A.17	language ("methadone and other approved medications", "opioid replacement medications", "drugs"). SAMHSA should be spelled out.	approved medications" or "medications". Opiate should be opioid.	revised to reflect this non-substantive change.	changed as recommended.
#11BH; #12BH; #13BH; TPC	1.6 C	LMHCs have been left out of list of licensed independent practitioners who can provide clinical supervision	LMHCs are included in definition in 1.6.C.1.e, also include in list in C.1.a	Language will be revised to reflect this non-substantive change.	Language will be changed as recommended.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.2 B.5, 1.6.7 C.1.2, 1.6.13 A.15.b, 1.6.13 B.1.1	References to American Society of Addiction Medicine are out of date. PPC was dropped in Oct 2013's version.	ASAM PPC should be changed to ASAM Criteria.	Language will be revised to reflect this non-substantive change.	Language will be changed as recommended.
#11BH; #12BH; #13BH; TPC	1.6.2 H	"The biopsychosocial assessment shall be rewritten in its entirety every 60 months." This does not reflect how most EHRs work; not a block of text that gets written and re-written.	Redraft this section.	Language will be revised to reflect this non-substantive change.	The term "rewritten" will be changed to "conducted." Language in this section does not dictate how it should be reflected in the treatment record.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.3	Language in this section does not reflect the most current language when speaking to recovery.		Language will remain the same.	If there are specific recommendations for revision they will be entertained in 2019.
#7BH Comment ID:	1.6.3.5 B	"Validation shall be recorded no later than two weeks after	The required signature?	Language will remain the same.	Validation must be signed by qualified supervisor other than the

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#10211-25 Wendy Looker OTARI		completion of the plan." Define validation.			writer.
#7BH Comment ID: #10211-25 Wendy Looker OTARI	1.6.6 G	In an outpatient setting, how long should records remain open? RIBHOLD requires update & closing records on a daily basis.	Will this conflict with RIBHOLD requirements?	Language will remain the same.	Agency record closure criteria is defined by items G 1,2 & 3 and not by a specific length of time. BHOLD's purpose does not conflict with these regulations.
#6BH Comment ID: #10211-22 Ruby Nicholson Thrive	1.6.6 G.1	Duration unclear re: leaving open records of individuals determined at risk of relapse, hospitalization, or homelessness.	When can they be closed? 3 months, 6 months?	Language will remain the same.	Agency record closure criteria is defined by items G 1,2 & 3 and not by a specific length of time.
#9BH Comment ID: #10211-14 Cynthia Wheeler Newport #8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.7 A	Regulations on provision of crisis services out of date.	Make changes in light of services already funded such as BH Link.	Language will remain the same.	Community Mental Health Centers are still required to provide crisis or emergency services as described in § 40.1-8.5-2 based on procedures established by the Mental Health Law §40.1-5-7 .
#11BH; #12BH; #13BH TPC	1.6.7 A.7	First page of regulations states it does not pertain to hospitals, but lists "licensed hospitals". Out of date to provide		Language will be revised to reflect this non-substantive change.	Language will be revised as follows: Each CMHC performing psychiatric emergency service triage shall

Source	Referenc e	Summarized Comment	Suggestion from Source	Departmental Position	Response
#9BH Comment ID: #10211-14 Cynthia Wheeler Newport		Director with annual list of QMHPs.			provide the Director of BHDDH with an annual list of its personnel who qualify under statute or regulation as a QMHP and act in that role. 1.6.7.8 will be deleted because it is duplicative with the addition of the revised language.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.7 D.4.d	Should read “substance use evaluation”.		Language will be revised to reflect this non-substantive change.	Will update language
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.8 N, 1.6.12 F.5, 1.6.14 A.12.a, A.12.b, A.13, A.14, A.15.b	“Drug testing” and “UDT” are outdated language.	Replace with “urine toxicology screens”.	Language will be revised to reflect this non-substantive change.	Language will be changed as recommended.
#7BH Comment ID: #10211-25 Wendy Looker OTARI	1.6.9	Does this section apply to OTP’s who provide only substance abuse services?		Language will remain the same.	1.69 applies to all BHOs. Per Federal Opioid Treatment Standards 42 CFR §8.12(f)(1) Required Services- General: OTP’s shall provide adequate medical, counseling, vocational, educational and other assessment and treatment services.
#8BH Comment	1.6.9 A.2	Many entities offer guidelines and toolkits.	Reference to SAMHSA should be	Language will be revised to reflect	Language will be revised to reflect use of

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ID: #10211-26 Susan Storti SUMHLC			removed.	this non-substantive change.	evidence-based practice toolkits generally.
#9BH Comment ID: #10211-14 Cynthia Wheeler Newport	1.6.11 1.6.11 A.1.b, 1.6.11 B.1.b	Detailed staffing models for IHH/ACT already in program manual and should not be in regs; does not allow for adaptation to new research. Inclusion of DLA-20 does not allow for adoption of an improved instrument in the future. Too prescriptive that clients with lower DLA scores are not eligible for IHH service. As written, clients with a 3.0 DLA are also not ACT eligible. This DLA range does not truly manage the population	Reference a copy of the most current IHH-ACT manual instead.	Language will remain the same.	Staffing patterns and DLA requirements meet current Medicaid State Plan Amendment requirements.
#2BH Comment ID: #10211-11 Lynn Costigan-Serra	1.6.12 F.4.A	Define “a qualified behavioral practitioner”.	Is this a clinical supervisor?	Language will remain the same.	1.6.C. contains a list of qualified behavioral practitioners.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.14 A.6.a	Need to include language that if no documentation of 1 year of OUD then long-term detox is available up to 180 days with a determination by MD or taper off or switch		Language will be revised to reflect this non-substantive change	Language will be revised to reflect this non-substantive change and will be moved to 1.6.14.A.6.b.

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		to MMT.			
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.14 A.6.19	Unclear. Sounds like after 2 detoxes they should be referred out of MAT.	42 CFR part 8's intent is to not continue detoxing.	Language will be revised to reflect this non-substantive change	Language will be revised to reflect this non-substantive change and will be moved to 1.6.14.A.6.c to improve flow and clarity. It will align with 42 CFR 8.12 e (4).

Health Homes

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
#7BH Comment ID: #10211-25 Wendy Looker OTARI	1.6.14 B.2	Why is there a requirement for OTPs to provide home health services to eligible clients and not for CMHCs? This means OTPs must be accredited as a health home, which is an added expense above accreditation. Not factored into reimbursement rate and costs between $4,000 - $12,000 per cycle.	Recommend making it optional as it is with CMHC's.	Language will remain the same.	The state plan amendment (SPA) requires automatic enrollment of participants for both Health Home services. Participants may opt out. Accreditation as a Health Home is not required by the Department. Providers are expected to meet all requirements necessary for Medicaid billing.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	(Unspecified)	HH programs were structured to specific guidelines set forth by the federal government, proposed at specific times, with different populations and needs than exist presently. Numerous issues	Inclusion of HH programs as they appear should be reconsidered.	Language will remain the same.	See response above.

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		regarding management of the program under managed care, workforce expectations, billing and payment issues, prompting preliminary conversations regarding a review and restructuring of the system as a whole. Changes have already been approved not reflected in these regulations.			

Staffing

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
#11BH; #12BH; #13BH TPC	1.6.12F.4.c(1)	Required staffing will add substantial, currently unfunded, costs. It adds to overall regulatory burden on BHOs and applies an uneven approach to staffing levels in different types of programs. Can conflict with staffing requirements under contract with health insurers. Hospital liaison position cumbersome to hospital staff fielding all of the messages.	Department should take a consistent approach for different types of programs, recommending maximum flexibility. Define hospital liaison position in terms of number of hospitals in service area or some other factor that provides consistent points of contact for hospital management.	Language will remain the same.	There is language at 1.6.12.F.4.c(2), 1.6.12.F.6.a(2) and 1.6.14.A.5d.(1) that allow for submission of an interim staffing plan subject to approval by the Department that defines specific staffing ratios.

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		Estimated minimum staffing for residential programs for SUD as written brings $500,000 additional costs to TPC treatment programs.			
#2BH Comment ID: #10211-11 Lynn Costigan-Serra	1.6.12.F.4 .c (1)	The minimum standard staffing pattern of direct care staff to residents approved by the Department is 1:8 – does this equate to 2 counselors if >8 residents?	Can this be 1 counselor and 1 overnight residential worker? Please define.	Language will remain the same.	16.12.F.4.c (1) (BB) defines the required overnight staffing. See response above.
#7BH Comment ID: #10211-25 Wendy Looker OTARI	1.6.14. A.5.d	Where does this regulation come from? How was the ratio arrived at? Concerned with shortage of clinicians. Does not take into account differing needs of patients and clinician ability.	Willing to meet with Department to determine a ratio that is appropriate. Asks that use of ratio be omitted until that time.	Language will remain the same.	See responses above related to the source of the ratios proposed.
#4BH Comment ID: #10211-14 Jamie Savage The Journey	1.6.14. A.5.d	Regulating caseloads of Opioid Treatment Facilities is unwarranted. It is an assumption that controlling ratios leads to improved clinical care, access and outcomes. Moving toward 1:60 ratio is mandating an increased staffing level without increasing financial support, and it is not evidence-based.	Consider more room for group treatment model, which is in line with SAMHSA and ROSC. Group model has been demonstrated effective in Hazelton and the Texas Christian University. Moving towards a group model would be the most efficient and evidence-based implementation that would provide	Language will remain the same.	See response above.

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		SAMHSA and CARF provide standards and best practices and do not suggest specific ratios. Clinics generally run 65 to 85 per clinician along with case managers and nurses. One case could have 3 people involved in their treatment, leading to a 3:75 ratio instead of 1:75 ratio, so ratio is not an accurate reflection of treatment. If a clinic has a 1:65 ratio and they have 350 individuals in treatment, but is moved to a 1:60 regulation, they would need to hire an additional clinician to equal 6 full time equivalents. 18 states require case ratios in Opioid Treatment Programs. Maryland requires 1:50 ratio but provides the ability for facilities to be viable and restructured their bundled rate and removed individual and group counseling services out of their bundled rate.	positive clinical outcomes in a fiscally responsible climate. Recommend looking at other state systems, e.g., Maine, Massachusetts, Connecticut, California, Maryland, South Carolina, Vermont, which allow for greater flexibility in determining “clinically necessary” staff ratios and sometimes provide specificity on hours of counseling required. Review research (Finnell and Lee) endorsing patient choice in treatment approach.		

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		Active Regulation 45.13.1 determines minimum requirements for individual and group counseling and leaves room for group treatment practice, allowing programs to manage higher caseloads while managing their workloads. Operating a group model with 1:85 ratio using the active regulation above would allow the case load's work to be divided up in 3 months rather than the 1 month discussed with just individual treatment.			
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	Unspecified	Addition of regulatory burden on BHO's, especially as it pertains to staffing, is concerning. In some cases, proposed staffing levels would increase costs substantially. The specificity outlined as it pertains to the workforce is troubling. Viability of programs treating vulnerable populations would be especially at risk. Secondary to		Language will remain the same.	Refer to the Cost Benefit Analysis.

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		reimbursement rates, even if they could be recruited, community providers may not be able to retain them as they tend to seek employment in settings with higher wages. “Payer” staffing requirements and other requirements may not align with Department regulations, adding further burden.			

General Comments

Source	Refere nce	Summarized Comment	Suggestion from Source	Departmental Position	Response
#7BH Comment ID: #10211-25 Wendy Looker OTARI	1.4.2	Please define a behavioral health crisis.		Language will remain the same.	Each organization may create their own definition, but the intention is to ensure that there are clear policies addressing how the organization will support staff when behavioral health issues prevent the staff member from performing duties assigned to them.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.3.1	Section 1.3.1 Definitions The following definitions should be considered for inclusion: -“Center of Excellence” “Medical Clearance” “Comorbidity”	as individuals experiencing substance use disorders or Comorbidity – the co-occurrence of mental and physical disorders in the same person,	Language will remain the same for “Center of Excellence” and “Comorbidity.” “Medical Clearance” will be	“Center of Excellence” and “Comorbidity” are not used in the proposed regulations. “Medical Clearance,” while used in the Opioid Treatment Program section, was not

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			regardless of the chronological order in which they occurred or the causal pathway linking them.	added in the future.	defined in the previous set of regulations.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.1 D.7	States that rules do not apply to “Groups of practitioners… or association”. How are large group practices prescribing buprenorphine products going to be monitored?	Should be addressed due to recent data from SAMHSA indicating buprenorphine is being diverted at alarming rates.	Language will remain the same.	Prescribers are licensed by other agencies and are outside the purview of these regulations.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.5	Language from 1.5 should be moved to 1.26 Individual (Participant) Rights (Licensing Regulation) for ease of reading	Move language from 1.5 to 1.26 of Licensing Regulation.	Language will remain the same.	The rights are specific to those in licensed BHO residential programs.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.1 H, 1.6.2 J, 1.6.3 D, 1.6.4 D, 1.6.5 E, 1.6.6 I.	Significant concern regarding the influence and expectations of “payers” on delivery of services and documentation. Could prove devastating to organizations as there is a financial cost to implementing changes within EHRs to meet each payer’s expectation.		Language will be revised to reflect this non-substantive change.	The clause, which was intended to reduce burden by attempting to align with payer expectations for treatment documentation, will be removed.
#6BH Comment ID: #10211-22 Ruby	1.5.3 D	Grievance procedure requires reporting directly to Director of the BHO. Some situations require investigating with	Human Rights Officer should be accepted alternative to Director as they will be investigating it. Also include clause regarding	Language will remain the same.	The regulation requires the BHO director to forward the grievance to the HRO, but nothing in the regulation prevents a person from filing it with

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Nicholson Thrive		several staff members who may be out/ill/unavailable.	time period to accommodate delays, and an option of a verbal response to individuals who prefer it, with written records retained on-site.		the HRO. Section 1.5.3E indicates that the HRO assists in investigating grievances, which by operation of the regulation would become the HRO's primary role in the event the director was the subject of the grievance. Any lack of access to involved staff should be referenced in the required ten-day report to BHDDH, but such absence should not delay implementing any required safety plan.
#6BH Comment ID: #10211-22 Ruby Nicholson Thrive	1.6.3 B.7	Limited amount of psychiatry time with clients will be further reduced if psychiatrist must sign all treatment plans for assertive community treatment services.	This requirement would add a signature to treatment plans, not value to the service.	Language will remain the same.	Physician involvement on an ACT team is required.
#9BH Comment ID: #10211-14 Cynthia Wheeler Newport	1.6.8 M	Level of reporting requirements are applied similarly to serious concerns such as theft and loss of medication and to minor administrative errors usually handled through supervision.	Revise requirements. Reexamine unprecedented reporting requirements of med errors to RI Board of Pharmacy.	Language will remain the same.	This is required under federal and state statutes and regulations.
#8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.8 N.1	"Individuals at their own expense may have their test confirmed" is discriminatory against low income individuals.	Screening is done at almost all agencies, especially outpatient, as part of the bundled rate. All positive screens	Language will remain the same.	Medicaid reimbursement may be available.

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		Given screening of Fentanyl and ever-changing analogs, urine screens can be false positives at a high rate.	should be confirmed all the time, not just when patient can afford it.		
#9BH Comment ID: #10211-14 Cynthia Wheeler Newport	1.6.9 A.12	Requirement for gender specific treatment groups too restrictive.		Language will remain the same.	This is required by federal regulation called for in 45 CFR §96.124 https://www.ecfr.gov/cgi-bin/text-idx?SID=9b418e83dbef693e0fcdab7852ed1188&mc=true&node=se45.1.96_1124&rgn=div8; and also in 45CFR §96.131 https://www.ecfr.gov/cgi-bin/text-idx?SID=9b418e83dbef693e0fcdab7852ed1188&mc=true&node=se45.1.96_1131&rgn=div8
#11BH; #12BH; #13BH TPC #8BH Comment ID: #10211-26 Susan Storti SUMHLC	1.6.9.5 A.8.b	"A pregnancy test must be given to all women of childbearing age" interferes with the scope of practice for physicians set down by DOH.		Language will be revised to reflect this non-substantive change.	Requirement for pregnancy test for co-occurring disorder will be eliminated from this section.
#9BH Comment ID: #10211-14 Cynthia Wheeler Newport	1.6.12 B.4.f	Requirement for provision of external smoking areas for MHPRR services does not support smoke-free centers.		Language will remain the same	This applies to residential programs not to BHOs in general.
#6BH Comment ID: #10211-22	1.6.15 2	Where will agencies procure take-home naloxone to provide to	Will the Department have a supply that can be obtained? If not,	Language will be revised to reflect this non-	The Department will change language to the following: Individuals

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Ruby Nicholson Thrive		persons with a history of an opioid use disorder?	what expense will this be to the organization?	substantive change.	receiving residential services or medical detoxification services will be advised on the availability of naloxone.

General Comments without Specific Reference

Source	Reference	Summarized Comment	Suggestion from Source	Departmental Position	Response
#1BH Comment ID: #10211-10 Mary Dwyer	NA	No mention of CSP/CSS designation criteria. Has this gone away?		Language will remain the same.	CSP/CSSS was service category that currently serves as a data reporting proxy for identifying clients as having a high acuity level of mental illness. The designation is not inconsistent with regulations but also not included in them.
#11BH; #12BH; #13BH TPC	NA	Regulations were developed without input from payers, especially insurers, creating higher overall burden of regulations.		Language will remain the same.	The regulations reflect a commitment by the Department to ensure safety and quality and fulfill duties required by statute which include establishing service standards. See RIGL 40.1-5-3 and 40.1-5.4-4. The service standards should drive the reimbursement rates and payment structures, rather than the other way around.
#7BH Comment ID:	NA	Why, after months of meetings and		Language will remain the same.	The Department will reconvene the

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#10211-25 Wendy Looker OTARI		committees, is this drastically different from what was discussed?			stakeholder groups in 2019 and will entertain recommendations for amendments at that time.