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

11/16/18

COMMENT #	FROM	COMMENT	RESPONSE Location
#1BH Comment ID: #10211-10	Mary Dwyer 09/26/2018 Online	There is no mention of CSP/CSS designation criteria. Has this gone away? This is an important area for clarification from which other comments may arise.	*Review of Public Comments* p. 15
#2BH Comment ID: #10211-11	Lynn Costigan-Serra 09/26/2018 Online	Section 1.6.12 Residential Services Section F Residential Programs #4 Staffing A. Services are coordinated by a coordinated treatment team that includes a qualified behavioral health practitioner who coordinates the plan of the person serviced...... Please define 'a qualified behavioral practitioner'. Is this the clinical supervisor? Also, 4 c (1) The minimum standard staffing pattern of direct care staff to residents approved by the Department is: AA. One direct care staff to eight residents........ Does this equate to (2) counselors if more than eight? Or can it be (1) Counselor and (1) overnight residential worker. Please define.	Pages 7, 9
#3BH Comment ID: #10211-12	Lynn Costigan-Serra 09/26/2018 Online	Not displayed to public Are Behavioral Healthcare Organizations going to be required to be accredited by JCAHO or CARF?	Page 3
#4BH Comment ID: #10211-14	Jamie Savage 09/27/2018 Online Attachment #4BH Journey attmt	Attachment pasted below: The Journey to Hope, Health and Healing would like to thank BHDDH in allowing us to be a part of the regulation revision committees. Now that the revisions have been posted for comment, The Journey has some concerns that we think have a negative impact on our industry. We have one area that we will be commenting on for the proposed regulation in Title 212, Chapter 10, Subchapter 10, Part 1.6.14. Regulation A.5.d "*Clinical staff caseloads should not exceed an average staff to client ratio of 1:60*".	Page 9

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		The Journey to Hope and Health and Healing argues that regulating caseloads of the Opioid Treatment Facilities is unwarranted, financially damaging under current reimbursement rates which will impact the individuals we care for by cutting costs in other areas to ensure viability. It is an assumption that controlling ratios leads to improved clinical care, access to services and improved outcomes. Moving towards a 1:60 ratio is mandating an increased staffing level without increasing financial support. It's simply not efficient not evidence based and to add SAMSHA and CARF who provide standards and best practices do not suggest specific ratios in relation to the proposed regulation. This response will suggest more of an efficient view that will maintain clinical effectiveness through utilization of evidence-based treatment, ensure program viability and fidelity without increasing costs which will have a negative effect on patient care. The caseload cap is essentially an unfunded mandate much like other similar decisions that have caused great harm for the population it was intended to support. There is an unintended consequence for mandating a ratio. Clinics generally run 65 to 85 per clinician along with those cases are case managers and nurses that provide direct support to those shared cases. One case could potential have 3 people involved in their treatment not to mention the medical provider, administrative support and other staff that work behind the scenes. For example, using a 1:75 ratio, in actuality it's a 3:75 ratio for most cases as the caseload and work load is shared by more than one person. If we were to assume that one clinic runs with a 1:65 ratio and they have 350 individuals in treatment which results in budgeting for 5 clinicians. With a 1:60 ratio, an additional clinician would need to be hired to equal 6 full time equivalents. On the higher end of 1:85 which would require 4 full time equivalents, a 1:60 would require that agency to hire two additional staff at the same reimbursable rates. These examples would require adjusting their budgets and make those changes to ensure viability. Organizations could cut back on other staffing positions, change the quality of their supplies,	

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		change vendors with unforeseen consequences. These are only some areas that organizations could adjust to maintain operations. There are 18 states that require case ratio's in Opioid Treatment Programs and some of those treatment centers are residential. Maryland is one of the states that does require 1:50 ratio in an outpatient opioid treatment facility. Maryland recognized that it was impossible to mandate this ratio without providing the ability for facilities to be viable and restructured their bundled rate and removed individual and group counseling services out of their bundled rate. This allowed treatment centers to bill a fee-for-service rate for those services separately. Maryland is only one example of other states that required caseload ratios where treatment facilities were given the resources to perform effectively with a 1:50 ratio. Rhode Island is proposing that facilities operate under a 1:60 ratio in a financial climate that is already stressed placing organizations in financial jeopardy by not providing the resources to perform at a 1:60 ratio. Another recommendation to support the idea of not mandating a 1:60 ration is to focus on evidence-based models such as the group model. Currently, regulations do not mandate or provide guidance for caseload ratio's for counseling in outpatient OTP programs that provide buprenorphine, vivitrol, and methadone . Active Regulation 45.13.1 determines the minimum requirements and states, "A minimum of one (1) hour of individual counseling must be provided monthly (in one (1) or two (2) sessions) and shall be documented in the individual's treatment record for the first year of treatment". Regulation 45.13.3 reports "after the first year of treatment, each person who is participating in group counseling, on at least a monthly basis, shall receive a minimum of (1) hour of individual counseling every (90) days)" and, 45.13.4, "Each individual, who is not participating in group counseling, shall receive at least one (1) hour of individual counseling every (30) days. Current regulations 45.13.1, 45.13.3, and 45.13.4 have been continued without revision in the new proposed regulations 212-RICR-10-1. These regulations sited above allow programs to manage higher caseloads while managing their workload. For example, implementing an effective and efficient evidence-based group model	

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		could manage an 85:1 caseload by managing the workload. As just an example where patients are only seen individually with an 85:1 ration would equal 85 hours per month direct with 160 hours a month working time. Taking 160 working and subtracting 85 direct face to face hours equals 75 hours left for the month. Those 75 hours divided up by 4 weeks is only 18.75 hours per week for additional indirect and direct work. If programs are only operating with an individual treatment focus with an 85:1 would be unreasonable and the states addition of a ratio cap of 60:1 would be a great improvement. Operating a Group Model with 1:85 ratio using regulations sited above would allow an 85:1 case load's work load to be divided up in three months rather the 1 month discussed with just individual treatment. For example, would an 85:1 ration would be divided up in 3rds which equals 28 direct hours per month resulting in 132 hours. Dividing 132 hours throughout the month would then equal weeks 33 hours per week. If two (2) groups occur five (5) days a week being 1 hour long equals 10 hours between 4 staff assuming the clinic census is 340 patients. The 10 hours divided up between staff is 2.5 hours per clinician leaving 30.5 hours. If 28 patients are equally seen throughout the month 7 patients would be seen a week out of 30.5 hours. This provides 30.5 hours a week to manage 7 hours of direct face to face sessions is more than sufficient to manage a 85:1 workload with also support from case managers and nurses. Here are some pros and cons for individual vs. group treatment 1. Group therapy assures individuals that they are not alone and that other individuals share similar problems and struggles. 2. Group therapy offers the opportunity to both receive support from others and to give support to others. Both of these notions are important in treatment. Receiving support from others is part of the bonding or therapeutic alliance that occurs in groups, whereas giving support to others allows for growth and learning. 3. The therapeutic alliance that occurs in groups is broader than the alliance that occurs in individual therapy. This allows for the incorporation of many different points of view. 4. Group therapy helps individuals develop communication skills and socialization skills and allows clients to learn how to express their issues and accept criticism from others. 5. Sharing one's experiences with others with similar problems is often itself therapeutic.	

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		6. Group therapy provides a broad safety net for individuals who may otherwise be hesitant to discuss their feelings, perceived weaknesses, etc. 7. Individuals in group therapy can model the successful behaviors of other individuals who have gone through similar experiences. Modeling is a form of learning where individuals learn by copying or imitating the actions of others. 8. Group therapy may be inappropriate for certain types of individuals, such as individuals who are extremely antisocial, extremely shy, impulsive, passive-aggressive, psychotic, etc. 9. Groups typically meet at specific times. There is less opportunity to fit the therapy into the one's personal schedule. 10. Although the therapeutic alliance is broader, it is not as focused and strong in group therapy as it is in individual therapy. 11. Some individuals in groups do not actually make changes but simply ride on the success of others. Groups may allow unmotivated individuals to hide their issues and avoid accountability. 12. The level of confidentiality in groups is far less secure than it is an individual therapy. Although group members are generally instructed that the information and events that occur in the group are to be held confidential and only to be shared with group members during therapy, the potential for a breach of confidentiality is far greater in group therapy. The argument is that a 1:60 mandated ratio will be disastrous to the population we serve. Either resources are provided to the organizations or opioid treatment organizations are not forced to maintain 60:1 ratio. Moving towards a group model would be the most efficient and evidence-based implementation that would provide positive clinical outcomes in a fiscally responsible climate. Group models such as Hazelton and The Texas Christian University provide evidence-based group models that are vetted and supported by SAMSHA. Rhode Island has always been innovative, and our ideas are great, this is another area where being more restrictive would not	

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		align with our spirit. It's also important to add that if the 1:60 is in response to manage our opioid epidemic, it's a faulty notion since we know that the people in treatment live. The ROSC approach recognizes that there are many "pathways" to an individual's recovery. That recovery activities need to include a "menu" of treatment services that an individual can choose. A "person-centered" perspective can enhance engagement of individuals with their achievement in recovery. Although our suggestion has a group focus, we do not discount the importance of individual treatment and patient choice. The U.S. Department of Health and Human Services conducted a study that was published in August 2009. The study reviewed 12 guiding principles of recovery and 17 elements of recovery-oriented systems of care. The elements that are relevant to this request and found as a viable and important element to recovery concluded that recovery needs to be "individualized and comprehensive services across the lifespan", that treatment is in "partnership-consultant relationships", and "Recovery is self-directed and empowering". Providing a group model still fits into a ROSC perspective that can be individualized although that there is a structure to the model. **The Support** Under the Federal opioid treatment standards (42 CFR 8.12.5) discusses the guidelines for counseling services. Opioid Treatment Programs "must provide adequate substance abuse counseling to each patient as clinically necessary" (42 CFR 8.12.5, pg14). The section continues to discuss by whom the counseling will be provided by and their qualifications but does not provide limitations to the frequency or ratio for non-group counseling. The regulation places that determination on what's "clinically necessary". In review of the State of Maine's Regulations, CMR 19.8.5.5.2(pg.23) discusses the counseling requirement as being a "total 4 (four) hours of counseling that could include individual counseling, group counseling, psycho-education, psychodynamic or support groups sessions" for patients who are in induction. For patients who are defined as acute, CMR 19.8.5.6.2 (pg.	

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		23-24) requires counseling to “total 6 (six) hours of counseling that could include individual counseling, group counseling, psycho-educational, psychodynamic or support group sessions.” Patients who are in rehabilitation is discussed in CMR 19.8.5.7.2 (pg.24) suggests the same level of care for patients defined as being in “Acute Treatment” (pg.23). The Maine regulation supports level of service by what is clinically necessary for the identified patient. The regulation also allows patients to make choices about their treatment allowing them to decide how many individual and group meetings they attend. Maine’s implementation of their regulations also supports the Recovery-Oriented Systems of Care (ROSC). The regulations for Massachusetts in Opioid Treatment describe minimum treatment service requirements in 105 CMR 164.074. Minimum requirements in this section does not describe or give limitations to the amount of individual counseling and group counseling that a patient is required to attend. The levels of services are determined by 105 CMR 164.073 part A.3, leaving the decision of appropriate level of care to the development of the patient’s treatment plan. In discussing the Massachusetts 105 CMR Licensure of Substance Abuse Treatment Programs, CMR 164.074.A states “Substance abuse therapies, counseling and education which conform to accepted standards of care must be provided directly by licensee”. Officials have not defined Connecticut State regulation with the frequency or a particular treatment intervention. The State recognizes the Federal opioid treatment standards in 42 CFR 8.12.5, Opioid Treatment Programs “must provide adequate substance abuse counseling to each patient as clinically necessary”, (pg14). Connecticut supports the levels of treatment developed and agreed upon from the patient and the clinician. California’s regulations for MAT (Medically Assisted Treatment) are sited in California Administration Code title 9.10345, Barclays Official California Code of Regulations, Title 9 Rehabilitative and Developmental Services, Division 4., Department of Alcohol and Drug Programs, Chapter 4., Narcotic Treatment Programs, Subchapter 5., Patient Treatment, 10345., under Counseling Services in Maintenance Treatment.	

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		Counseling services are defined as the following: (a) Upon completion of the initial treatment plan, the primary counselor shall arrange for the patient to receive at the licensed program a minimum of 50 (fifty) minutes of counseling services per calendar month, except as allowed in paragraph (e)(4) of this section, and shall be in accordance with the following: (b) A counseling session shall qualify for the requirement in Subsection (a) of this regulation if: (1) The program staff member conducting the session meets minimum counselor qualifications, as specified in Section 10125. (2) The session is conducted in a private setting in accordance with all applicable federal and state regulations regarding confidentiality. (3) The format of the counseling session shall be one of the following: (A) Individual session, with face-to-face discussion with the patient, on a one-on-one basis, on issues identified in the patient's treatment plan. (B) Group session, with a minimum of four patients and no more than ten patients and having a clear goal and/or purpose that is a common issue identified in the treatment plans of all participating patients. (C) Medical psychotherapy session, with face-to-face discussion conducted by the medical director on a one-on-one basis with the patient, on issues identified in the patient's treatment plan. (c) The following shall not qualify as a counseling session for the requirement in Subsection (a) of this regulation: (1) Interactions conducted with program staff in conjunction with dosage administration. (2) Self-help meetings, including the 12-step programs of Narcotics Anonymous, Methadone Anonymous, Cocaine Anonymous, and Alcoholics Anonymous. (3) Educational sessions, including patient orientation sessions specified in Sections 10280 and 10285. (4) Administrative intervention regarding payment of fees. (d) The counselor conducting the counseling session shall document in the patient's record within 14 (fourteen) calendar days of the session the following information: (1) Date of the counseling session;	

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		(2) Type of counseling format (i.e., individual, group, or medical psychotherapy); (3) The duration of the counseling session in ten-minute intervals, excluding the time required to document the session as required in Subsection (d)(4) of this regulation; and (4) Summary of the session, including one or more of the following: (A) Patient's progress towards one or more goals in the patient's treatment plan. (B) Response to a drug-screening specimen which is positive for illicit drugs or is negative for the replacement narcotic therapy medication dispensed by the program. (C) New issue or problem that affects the patient's treatment. (D) Nature of prenatal support provided by the program or other appropriate health care provider. (E) Goal and/or purpose of the group session, the subjects discussed, and a brief summary of the patient's participation. (e) The medical director may adjust or waive at any time after admission, by medical order, the minimum number of minutes of counseling services per calendar month as specified in paragraph (a) of this section. The medical director shall document the rationale for the medical order to adjust or waive counseling services in the patient's treatment plan as specified in Section 10305(h). The California regulation indicates that counseling interventions can either be in the form of group or individual as described in Cal. Admin. Code tit. 9, § 10345. The regulation also allows the medical director to "adjust" or "waive" counseling services if necessary. As discussed earlier with other states sited, California has allowed the freedom of choice when it comes to the delivery of clinical interventions. Also, with alignment with the ROSC, patients have control and choice over their recovery and treatment. The Rhode Island regulation in this area determines level of care for the patients with no knowledge of the individual's needs, strengths, and wants. Choice is something RI patients do not have when it comes to their level of treatment. California Regulations can be found at; (http://weblinks.westlaw.com/result/default.aspx? cite=9CAADCS1034 5 &	

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		db=1000937&findtype=L&fn=_top&pbc=DA010192&rlt=CLID_FQRLT3892746108238&rp=%2FSearch%2Fdefault.wl&rs=WEBL13.07&service=Find&spa=CCR-1000&sr=TC&vr=2.0) Maryland is also a state that does not mandate to which modality a patient receives counseling services. In Maryland's State Regulation 10.47.02.04 Outpatient Services Level 1 section D.4 reports that program services can either be "group or individual counseling sessions". Under regulation 10.47.02.04 Program Description defines patients who require less than 9 hours weekly for adults fall into the category of being able to have either group or individual sessions. Maryland Regulations can be found on line at http://www.dsd.state.md.us/comar/getfile.aspx?file=10.47.02.04.htm. In review of North Carolina's regulations, the regulations mandate that in the first year of treatment (2) counseling sessions are conducted. Counseling is defined in the regulation 10A NCAC 27g .3602 8 as "a face-to-face or group discussion of issues related to and of progress toward a client's treatment goals". North Carolina's State Regulations can be interpreted as a client centered regulation for those entering a medically assisted treatment. The treatment plan is used to guide and determine appropriate level of treatment identifying either a combination of individual and group or one or the other giving the patient choice. Regulations on this topic can be found at http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20g/10a%20ncac%2027g%20.3604.html and http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20g/10a%20ncac%2027g%20.3602.pdf South Carolina also allows room for what is clinically necessary and patient choice. Regulation Number 61-93 section 3202.C Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence states "As part of drug rehabilitative services provided by the NTP, each client shall be provided with individual, group and family counseling appropriate to his/her needs. The frequency and duration of counseling provided to clients shall be determined by the needs of the client." (pg72). The South Carolina regulation supports patient choice as deemed what is clinically necessary as determined by the patient and treating	

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		facility/clinician. This regulation can be found at http://www.scdhec.gov/administration/regs/docs/61-93.pdf for review. On the topic of counseling, The Vermont Department of Health defers to SAMHSA Tip 40 which discusses affective counseling services as individual or group counseling "for most patients"(SAMHSA Tip 20,pg63). In the SAMHSA Tip 40 the discussion continues to mentions that self helps groups are helpful as well but should be seen as an "adjunct" (SAMHSA Tip 40, Pg.63). In Vermont counseling is seen as either individual and/or group as out lined in the development of a patient's treatment plan. The regulations can be found at http://healthvermont.gov/regs/documents/opioid_dependence_rule.pdf for review. Finnell and Lee (2011) took a look at the psychometric properties for patient choices and decision in substance abuse treatment. In an earlier study by Finnell (2005) made the suggestion that when developing patients care that patients want to be "actively engaged with their providers" (2011, pg 243). Finell continues to discuss that based on that finding, moving to an "open choice" (pg.243) in substance abuse treatment to align more with how the culture of health care is changing towards being patient-centered perspective. This perspective considers patient preferences for treatment, needs, and values in clinical decisions. This "shared decision making" (pg.243) has to arguably flow through every aspect of an individual's treatment such as frequency of meetings, goal development, level of care, and defining progress through discharge. This process only "respects autonomy and promotes patient engagement"(pg.243). Finnell and Lee (2011) discuss that the evidence in a study by Sepucha, Fowler, and Mulley (2004) that the evidence for patients being in control of their treatment suggests that "treatment outcomes are improved when patients identify a preferred treatment"(pg.243), when it's their choice there's better engagement. Finnell and Lee (2011) present data from a study completed in 2008 by the Preference Collaborative Review Group where a meta-analysis of 1,398 patient's preferences was conducted. Based on treatment outcomes, "patients who received their preference had significantly greater improvements in treatment" (pg.244) when compared to those who did not	

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		have a choice.	
#5BH Comment ID #10211-20	Lisa Rafferty 09/28/2018 Online Attachment [#5BH Keystone attmt] This comment is for LIC and DD.	September 28, 2018 Rhode Island Secretary of State To Whom It May Concern, Please accept this letter as my public comment on the proposed BHDDH Regulations 212-RICR-10-00-1 and 212-RICR-10-05-1. First I want to thank the Director of Licensing at BHDDH for a thorough and inclusive review and rewrite of the regulations. It was an arduous task and he maintained his focus and good humor throughout the process. There are however a few errors and/or questions that I have about the final document. 212-RICR-10-00 • 1.20.1 Duty to Report o paragraph E is the same as paragraph A; o paragraph F is the same as D o paragraph L is the same as H o paragraph M is the same as I • Criminal Background Checks o There is redundancy around this issue 1.20.3 (A)(6) . . a policy that requires employees to report to the Organization any changes in the status of their criminal background check subsequent to their hire by the organization and reviewed annually 1.21 (A)(1) the organization shall have and shall implement personnel policies and procedures that: . . .(d) require employees to report to the organization any changes in their status of their criminal background checks subsequent to their being hired by the organization 1.21 (E) The annual evaluation process shall include the following: (4) review status of the employee criminal background check and enquire about possible criminal activity since the occurrence of the precious background check. o I recommend deleting 1.20.3(A)(6) as it is listed under Abuse, Neglect, Mistreatment and Other Human Rights Violations. And maintaining both 1.21(A)(1)(d) and 1.21(E)(4) as they are listed under Personnel. Employee Background Checks are a personnel requirement. • Fire Safety Training for Employees o Redundancy 1.20.3(B)Staff Training(1)(a) Minimum training for all employees: • (1) Fire training which includes training in the program's emergency evacuation procedures. 1.25.5 Fire Safety and Fire Drill Requirements • D. All direct service staff shall have specific fire training consisting of not less than 4 documented hours per year and shall include training in the organizations emergency evacuation procedures. . . I recommend deleting 1.25.5(D). I can find no requirement for a documented number of training hours in the fire code	Page 2

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		regulations. 4 hours per year per employee is excessive and that training time can be put to better use. 212-RICR-10-05-1 • Documentation Standards and Maintenance of Health Care Records o 1.11.3(D) Health care records shall be kept for a minimum of 10 years following the cessation of services This requirement has been increased from 7 years in the previous regulations Regulations for Nursing Homes (RI General Laws Chapter 23.3) that all medical records be preserved for a minimum of 5 years following discharge or death of the resident. o I recommend that the regulation be consistent with the nursing home regulations – a minimum of 5 years following discharge or death of the resident. Thank you for the opportunity to comment on the regulations. Comment By :	
#6BH Comment ID #10211-22	Ruby Nicholson 09/28/2018 Online	212-RICR-10-10-1 Thank you for the opportunity to respond to proposed regulation 212-RICR-10-10-1 and make the following comments and requests for clarification. Section 1.5.3 Grievance Procedure D. Must the person served initiate a grievance by filing a grievance with the Director of the Behavior Health Organization or can the client file his/her grievance directly with the Human Rights Officer? The Director of the Organization should be aware of grievances; however, if the Human Rights Officer is responsible for investigating the grievance it would make sense that the initiate grievance could go to either the Director or the Human Rights Officer. E. There are situations that may involve contacting several staff members to gather the necessary investigatory information and staff member input critical to the investigation cannot be obtained as the staff member is on vacation or out ill. I suggest a clause be added that "the individual filing the grievance be informed of the grievance process and time period in which to anticipate a response. In the event a decision cannot be reached within 10 business days the individual will be informed of the reason for the delay and anticipated date for resolution." Sometimes it is quicker to give an individual a verbal response to the decision and the individual does not want a written document. In these situations could the decision for a grievance be provided to the individual verbally with a written decision on file with a copy of the grievance and investigation process? Section 1.5.4 Behavior Management D. and F. Although there is extensive behavior management training for staff members in development disabilities systems of care, this is not the case for staff members working in	Pages 1,2,13,15

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		Community Behavior Health Organizations. Will the Department provide training opportunities for direct care staff in behavior management? How is training in behavior management defined? Will an in-house in-service be considered adequate or is the Department looking for more in depth training in this area? Section 1.6 Services and Programs B.3 & 4- Please define “preference.” Does “preference for a minimum of four hours of clinical supervision” mean 4 hours are required or that 3 hours are acceptable? Again, this section on clinical supervision is more a matter of counting hours rather than addressing clinical competencies. I suggest this section be re-written to focus more on what needs to be included in documented, on-going supervision and not so much on the time. Clinical staff members already have team meetings in which supervision topics can be addressed. Topics that should be addressed in supervision include: ethical decision making, cultural competencies, motivational interviewing, recovery principles, professional standards, staff performance, etc. Section 1.6.3 Person-Centered Treatment Plans B. 7. The limited amount of psychiatry time and need for that time to be spent with clients will be decreased if psychiatrist will need to sign all treatment plans for assertive community treatment services. Psychiatrists are already spending time at team meetings where cases and plans are discussed. Adding more time to sign on 100 treatment plans will bring no added value, only a signature. Section 1.6.6 Transition/Discharge Summary and Aftercare Plan G.1. If records of individuals determined at risk for relapse, hospitalization, or homelessness without services are to be left open, at what point can these records be closed – 3 months, 6 months, etc.? Section 1.6.10 Support Services 2 a. What is considered “appropriate training to supported employment and substance use?” Does this require specific training or can this be training provided by a supervisor during orientation or team meeting? Section 1.6.15 Overdose Prevention Education and Training 2. Where will agencies procure take-home naloxone to provide to persons with a history of an opioid use disorder? Will the Department have a supply that can be obtained? If not, what expense will this be to organizations? Thank you again for the opportunity to comment. Ruby Nicholson Director QI/HIM- Compliance- HRO Thrive Behavioral Health (formerly The Kent Center)	
#7BH	Wendy	The comments submitted are that of the majority of the Opioid Treatment	Pages

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Comment ID #10211-25	Looker 10/03/2018 Online Attachment #7BH OTARI attmt	Association of Rhode Island. In addition, these comments accurately reflect the position of Center for Treatment and Recovery in Pawtucket, RI. Attachment pasted below: In response to Title 212 – Department of Behavioral Healthcare, Developmental Disabilities and Hospitals Chapter 10- Licensing and General Administration Subchapter 10 Part 1 – Rules and Regulations for the Licensing of Organizations and Facilities Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals Dear Sir or Madam: First and Foremost, thank you for your effort in reviewing the regulations to meet the needs of the behavioral health landscape as it is today. However, upon review of these regulations it appears not only does it not reflect the behavioral health needs of today nor do they reflect forward thinking of the needs of tomorrow. After a review, it appears the bulk of these regulations are appropriate for the Developmental Delay (DD) population and/or Residential Population. Many of these regulations herein would not be appropriate for outpatient treatment, especially, Opioid Treatment Programs. This leaves me questioning the following: • At licensing audits would we be required to somehow meet regulations which are not necessarily applicable to an outpatient setting? • If we are not required to meet certain regulations set forth, how would this be determined, and would this information be included in the promulgation of new regulation to ensure agencies are protected from being cited on a regulation which does not pertain to their individual setting? Please accept the following questions and comments: Section 1.4.1: Please define a Behavioral Health Crisis. Section 1.4.2.C.1.E and F: Because of accreditation we are required to have a culture and diversity plan. Would this suffice for these two regulations? Section 1.6.3.5.B: Please define what Validation is “validation shall be recorded no later than two (2) weeks after completion of the plan.” Is validation the signature which is required? Section 1.6.5.G: In an OTP, how long should records remain open? We are	2,3,5,6,8,9,12,16

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		required to update and close records with RIBHOLD on a daily basis. Will this conflict with the RIBHOLD requirements? Section 1.6.9: Does this section apply to OTP's who provide only substance abuse services? Section 1.6.14 A.5.d. Where does this regulation come from? How was this ratio arrived at? First and foremost, Rhode Island has a workforce shortage of clinicians to provide services, especially in OTP's. For years we have shared our shortage concern with the Department. This ratio does not take into consideration the following: what is the acuity of the patient? How long have they been in treatment? Are they seen individually on a weekly, monthly or quarterly basis? What is the education, licensure status and abilities of the clinician? Generally speaking, patients new to treatment or struggling with recovery require more intensive treatment while those individuals who have been in treatment for numerous years require less intensive services. It seems arbitrary to put a ratio in regulation without consideration of all the factors involved including reimbursement rates, duties to be carried out by the clinician, state requirements of the frequency of counseling, etc. A full-time employee will average 173.3 hours per month. If you take out a minimum of 60 hours direct care, 4 hours supervision, 4 hours staff meeting, 15.2 hours lunch, and 20 hours per month to account for sick, personal, vacation, holiday time, you are still left with 70.1 hours per month for productivity. The Opioid Treatment Association of Rhode Island, which consists of five agencies and 16 locations are willing to meet with the Department determine if a ratio is appropriate and what the ratio should be while taking into consideration the above factors. We respectfully ask this be omitted until that time. Section 1.6.14.A.23.B.2: "OTP's must offer and provide Health Home services to clients who meet eligibility requirements." I am curious as to why this is a requirement for OTP's and not a requirement for CMHC's? Because we are required to offer these services, we are also required per the State Plan Amendment (SPA) to be accredited as a health home. The accreditation for health home is an added expense over and above accreditation. The cost of accreditation was never factored into the reimbursement rate. Dependent upon the number of locations an agency has the cost can be between $4,000 and $12,000 per accreditation cycle. In addition, reimbursement rates were slashed 39% to this program without a	

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		change in team composition resulting in a reimbursement rate which does not support cash flow needed to meet program staffing requirements set forth in the SPA. The requirement for OTP's to offer and provide health home services should not be required and be optional as it is with CMHC's. We respectfully ask this be omitted. OTP leadership spent months participating in various committees reviewing and revising the regulations to meet the Governors request of reducing the number of burdensome regulation and creating regulation which was not in conflict with accreditation or duplication of other State and Federal regulation. However, what was posted for review is drastically different from the draft regulations from those meetings. Without changes to the regulations as submitted before being approved, OTP providers will be in a difficult position for the round of licensing audits which will begin in early 2019. The Opioid Treatment Association of Rhode Island, which is made up of the 5 agencies and 16 locations, treating over 6,500 individuals on a daily basis is asking you review our recommendations and incorporate them into final regulation. Sincerely, Wendy M. Looker, RN, BS Chair Opioid Treatment Association of Rhode Island	
#8BH Comment ID #10211-26	Susan Storti, PhD, RN SUMHLC 10/05/2018 Online	PUBLIC COMMENT RE: 212-RICR-10-00-1 Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals CHAPTER 10 – LICENSING and GENERAL ADMINISTRATION SUBCHAPTER 10 – BHEAVIORALHEALTHCARE ORGANIZATIONS My name is Dr. Susan Storti and I am the President/CEO of the Substance Use and Mental Health Leadership Council of RI (d/b/a The Leadership Council). Thank you for the opportunity to provide comment today. The Leadership Council is a not-for-profit association comprised of 28 substance use treatment and/or behavioral health organizations, prevention coalitions, and student assistance programs employing more than 4,400 clinicians, medical professionals, and	Pages 4,5,6,7,8, 11,12,13, 14

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		other professionals providing behavioral health services to more than 20,000 patients across Rhode Island. The Leadership Council serves as forum through which member organizations channel their collective expertise to form a united voice of public advocacy for all persons with mental illness, addictions, and co-occurring diagnoses. Licensure and other mechanisms for regulating behavioral healthcare organizations Approximately 12 months ago, a group of stakeholders from the community were invited by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) to participate in review and revision of the current licensing regulations. This task of investigating current practices under which each type organization obtains licenses and accreditation was undertaken with participation of the stakeholder group. The group took a broad view of this charge, interpreting it to encompass the whole array of mechanisms including how licensure and other forms of governmental regulation, voluntary certification, and accreditation standards as well as how payer expectations interact with and influence all aspects of the system. Members of the Leadership Council took an active role in this process. When reviewing the proposed rules and regulations understanding the differences between licensure requirements, accreditation standards and, and certification processes are imperative. While there is often an interdependence between accrediting bodies, licensing authorities, and certification organizations the terms are not interchangeable. They each have a unique meaning and implication. Utilizing this lens, a review of the proposed Title 212 – Department of Behavioral Healthcare, Developmental Disabilities & Hospitals - Licensing and General Administration and Behavioral Healthcare Organizations was completed. Several areas of concern were identified and are listed below. SUBCHAPTER 10 – BHEAVIORALHEALTHCARE ORGANIZATIONS Section 1.1 Authority Purpose and Applicability D.7 While it states there rules do not apply to a "Group of practitioners …….or association", how are large group practices prescribing buprenorphine products going to be monitored? The most current data released by the Substance Use and Mental Health Services Administration indicates that buprenorphine is diverted at alarming rates. 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 mental health disorders	

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		often develop primary conditions and chronic diseases; Comorbidity – the co-occurrence of mental and physical disorders in the same person, regardless of the chronological order in which they occurred or the causal pathway linking them. 36. Opioid treatment program – - Should replace “methadone and other approved medications” with FDA approved medications. - SAMHSA should be spelled out - Opiate should be changed to opioid Section 1.4.3 Staff Competency and Training B. The organization shall provide training to improve knowledge, attitudes, and skills necessary for staff to conduct recovery-oriented services. Given the number of training opportunities offered online, webinar, etc. the statement should state that the organization shall provide and/or support participation in training Section 1.5 Rights of Persons Served in Residential Programs - For consistency and ease of understanding consider moving this section under the section1.26 Individual (Participant) Rights in Subchapter 00-N/A) There is a significant concern regarding the influence and expectations of “payers” on the delivery of services and documentation. The following statement is identified in each of the following sections: “The above is considered to be sufficient for the treatment record except as prescribed by a specific program, service, or payer.” 1.6.1 Clinical Screening –H 1.6.2 Biopsychosocial Assessment – J 1.6.3 Person-Centered Treatment Plan Review – D 1.6.4 Person-Centered Treatment Plan Review – D 1.6.5 Progress Notes – E 1.6.6 Transition/Discharge Summary and Aftercare Plan – I With the current re-design of the behavioral healthcare delivery system, this type of influence and expectation could prove to be devastating to organizations as there is a financial cost to implementing changes within EHRs to meet each payer’s expectations. Reference to American Society of Addiction Medicine When ASAM PPC is referenced it needs to be changed to ASAM Criteria, the PPC was dropped in Oct 2013’s version of ASAM. It is more than just PPC. ASAM is not required at any other point in care so it is being used as a PPC not a way to measure severity of illness, unfortunately. ASAM PPC is referenced in the following sections: 1.6.2 Biopsychosocial Assessment - B.5. 1.6.7 Outpatient Services and Programs – C.1.2 1.6.13 Detoxification Programs – A.15.b; B.1.1 Section 1.6.3 Person Centered Treatment Plan The language utilized in this section does not reflect the most current language when speaking to recovery. Section 1.6.7 Outpatient Services and Programs A – Emergency, Crisis Intervention and Crisis	

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		Stabilization Services. Will these change with the implementation of BH Link? D.4.d should read substance use evaluation Section 1.6.8 Medication and Laboratory Services N. Drug testing should be replaced with urine toxicology screens N.1. Individuals at their own expense may have test confirmed. This is discrimination against those who cannot afford confirmation testing. Screening is done at almost all agencies especially OTP's as screen are part of the bundled rate. All positive screen should be confirm all the time not just when a patient can afford it. With the screening of Fentanyl and the ever changing analogs urines screen can be false positives at a greater percentage. If patient doesn't have any funds they can prove that. Section 1.6.9 Services for Persons with Co-occurring Mental Health and Substance Related Disorders Section A.2 – Reference to SAMHSA specifically should be removed as there are many entities, both federal and non-federal, that offer guidelines and toolkits. A.8.b – A pregnancy test must be given to all women of childbearing age….addressed. This mandates interferes with the physician's scope of practice. Inclusion of the Health Home programs as they appear in these documents should be reconsidered as these are programs that were structured to specific guidelines set forth by the federal government. They were proposed at a specific points in time (i.e., 2010 with a revision in 2015 (IHH/ACT) and 2013 with a revision 2016 (OTP COEs) when the behavioral healthcare delivery system as well as the population that is presently being served was different. Additionally there have been numerous issues regarding the management of the program under managed care, workforce expectations, and billing and payment issues prompting preliminary conversations regarding a review and restructuring of the system as a whole. Additionally, changes have been approved that are not reflected in the document. Section 1.6.12 Residential Services F.5. - UDT should be replaced with urine toxicology screens Section 1.6.14 Medication Assisted Treatment A.2 – opioid replacement treatment medications should be replaced with FDA approved medications A.3 – as above 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 to taper off or switch to MMT. A.12.a, A.12.b, A.13, A14, A. 15.b, A.15.c. – replace drug testing with urine toxicology screening A. 16.a – replace opiate with opioid A.17, A.17.b – replace prescribed "drugs" with "medications" A.17.c – replace opioid replacement treatment with FDA	

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		approved A.6.19 - This is not clear. 42 CFR part 8's intent is to not continue detoxing, this sounds like after 2 detoxes they should be referred out of MAT. Additional Comments: The Leadership Council is concerned what appears to be the addition of regulatory burden on behavioral healthcare organizations, especially as it pertains to staffing. In some cases, the proposed staffing levels would increase costs substantially, putting the viability of programs to treat vulnerable populations very much at risk (i.e., intensive outpatient programs, partial hospitalization programs, opioid treatment programs, etc.). Additionally, the specificity outlined within the regulations as it pertains to the workforce is troubling. Given the state of the workforce, it may be difficult to recruit individuals with the required credentials. And even if they can be recruited, secondary to reimbursement rates, community providers may not be able to retain them as they tend to seek employment in settings with a higher wage. There is also the concern that "payer" staffing and other requirements may not align with the expectations set forth in proposed regulations leaving the provider community consistently challenged to meet all the requirements. Similar challenges are already posing a significant threat to the stability of the existing behavioral health service delivery system. Thank you for the opportunity to comment on the proposed rules and regulations as they apply to the licensing of behavioral healthcare organizations and for your consideration when reviewing these concerns. Susan A. Storti, PhD, RN, NEA-BC, CARN-AP President/CEO	
#9BH Comment ID #10211-27	Cynthia Wheeler Newport MH 10/05/2018 Online #9BH Newport MH	Please see attached response from Newport Mental Health. Attachment pasted below: Newport Mental Health Comments on 212- RICR-10-10-10 Regulations should be broad, over-arching guidelines for the provision of services. As currently written, the regulations are too prescriptive. 1.6.7 Item A The regulations on the provision of crisis services are too prescriptive, out of date, and do not allow for changes in light of services that are already	Pages 3,5,6,7,14,15

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		funded, such as the Statewide BH Link program. 1.6.7 Item A 7 The requirement to provide the Director with an annual up-to-date list of QMHPs is out of date. 1.6.8 Item M This particular requirement inappropriately applies a level of reporting to both serious and reportable concerns such as theft and loss of significant amounts of medication and to minor administration errors which are customarily handled through clinical supervision and corrective action. BHOs have never had the requirement to report medication errors to the Rhode Island Board of Pharmacy. 1.6.9 Item A 12 Although we agree with the benefit of providing gender specific treatment, the requirement for gender specific group treatment is too restrictive. 1.6.11 Detailed staffing models for IHH and ACT are already in the Program Manual and should not be included in the regulation since this does not allow the programs to adapt to practice changes based on up to date research. The inclusion of the DLA-20 in the regulations does not allow for the adoption of an improved assessment instrument in the future. Newport Mental Health requests a copy of the most current IHH-ACT manual referenced in this section. 1.6.11 Item A 1 b The DLA range does not truly manage the population. IHH services are provided to MHPRR clients with DLA scores lower than 3.0. It is also too prescriptive that clients with a lower DLA are not eligible for IHH service. 1.6.11 Item B 1 b	

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		The DLA range for ACT has been set at less than or equal to 3.0. As written, clients with a 3.0 are not ACT eligible. 1.6.11 Item B 4 Substance Use Disorder Specialist (BA level) requirement does not match the LCDP licensure requirements. 1.6.12 Item B 4 f The requirement for the provision of external smoking areas for MHPRR services does not support smoke free centers.	
#10BH	Annajane Yolken Haley McKee Lisa Peterson Co-chairs, SAOPPAC -- Substance Abuse and Overdose Prevention PAC Rhode Island Email	Good afternoon Ms. Theriault, The Substance Abuse and Overdose Prevention PAC is a non-partisan organization that provides education to voters and candidates about evidence-based substance use policies and overdose prevention efforts, takes positions on substance use and overdose prevention policies, and endorses candidates who are advocates committed to drug policies that uphold health, safety, and human rights. We are writing today to express our deep concern with the proposed changes to BHDDH licensing regulations. Criminal record checks and automatic exclusion from positions based on past arrests represent another barrier to employment in a system that already marginalizes individuals with behavioral health, substance use, and trauma-related diagnoses. Additionally, due to the racial disparities that exist within the criminal justice system, this type of regulation disproportionately affects individuals and communities of color. The categories of offenses which either immediately or essentially preclude applicants from consideration are so broad, and so common, that they will disqualify a large population who would not only benefit from meaningful employment, but who would be valuable contributors to the programs licensed by this agency. If we, as a state, are truly committed to effective approaches to behavioral health treatment and recovery, this revision cannot take effect. Instead, we should be partnering with individuals, community stakeholders, and employers to increase opportunities for people who have had contact with the criminal justice system so that they may re-engage in their communities	Page 2

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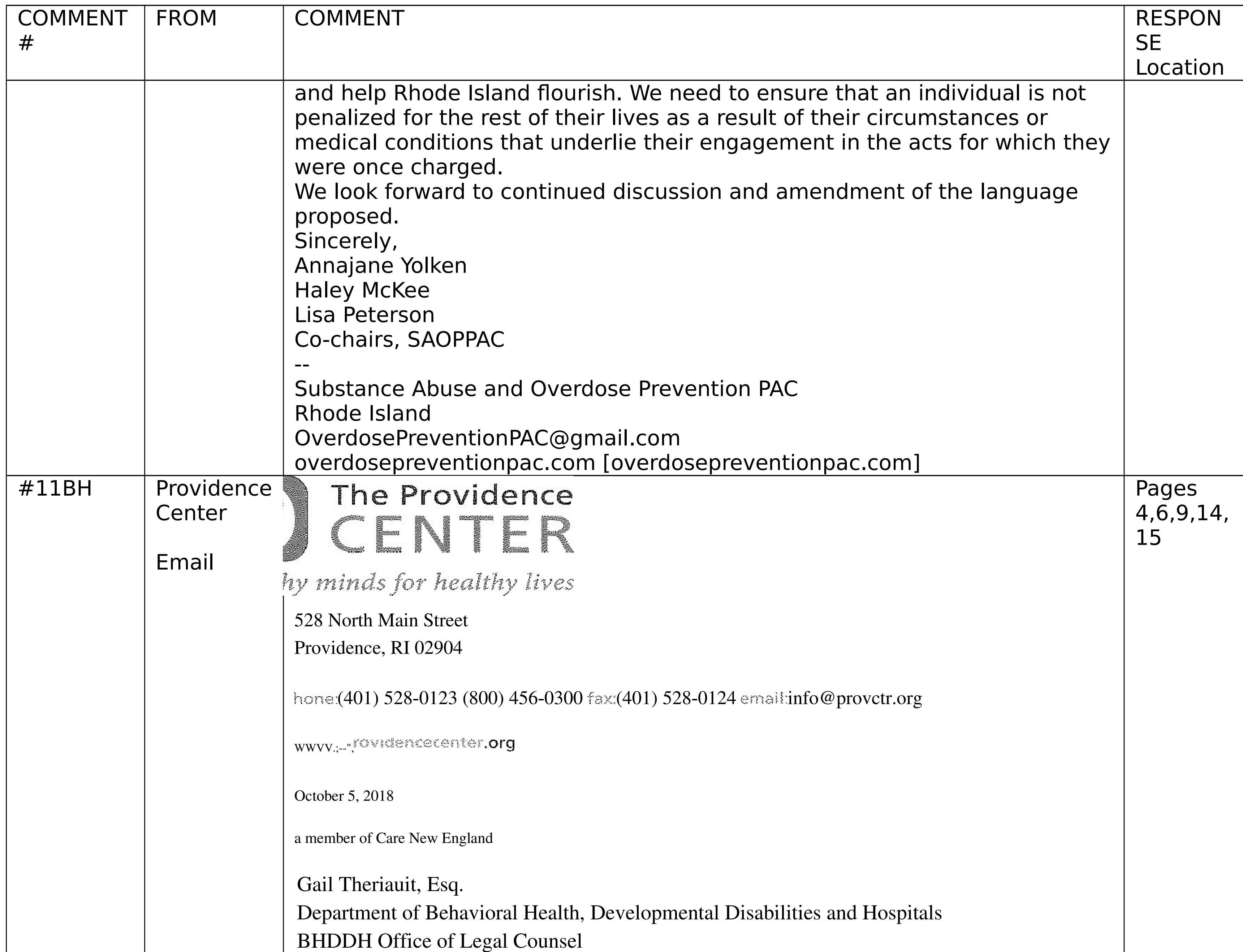
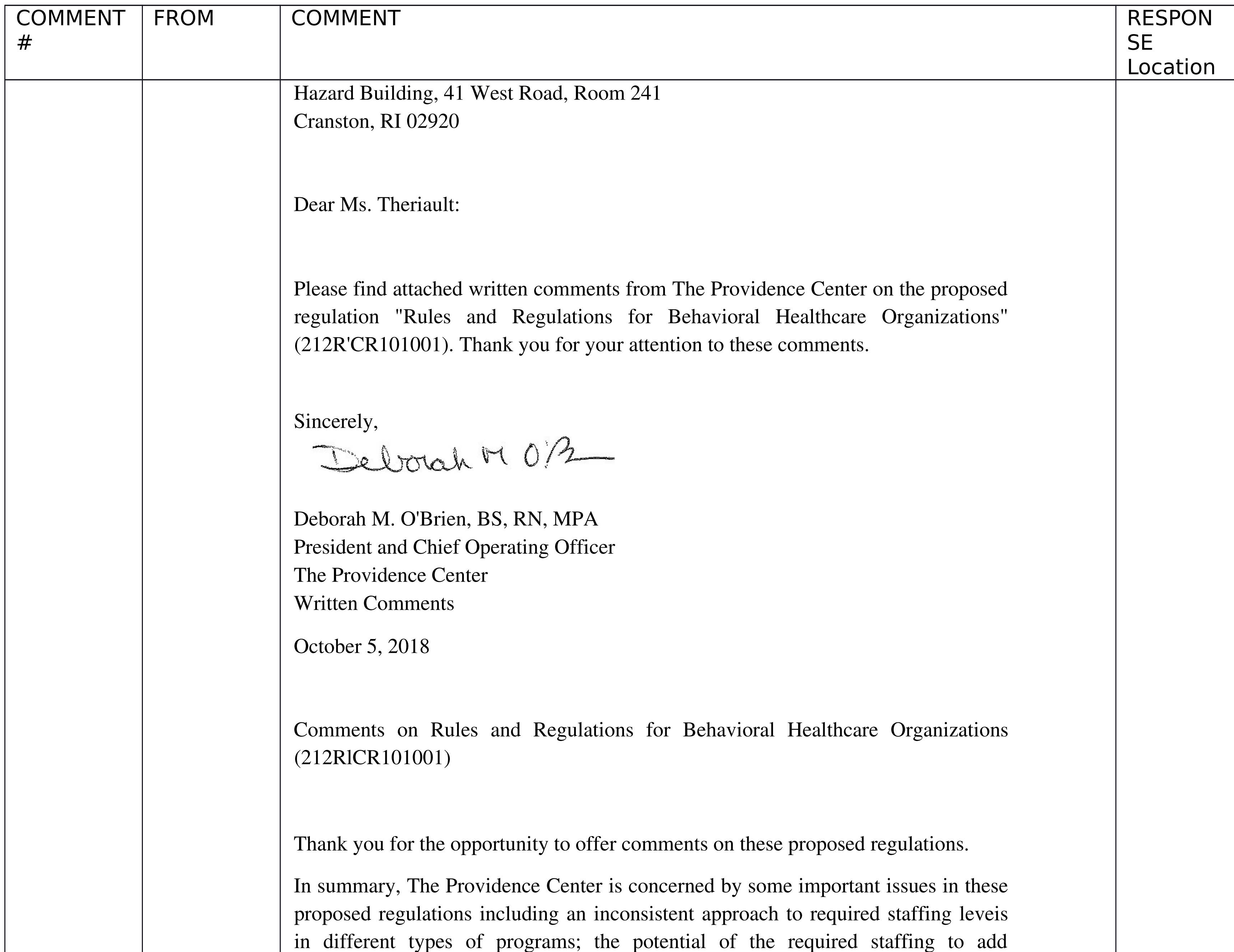
		and help Rhode Island flourish. We need to ensure that an individual is not penalized for the rest of their lives as a result of their circumstances or medical conditions that underlie their engagement in the acts for which they were once charged. We look forward to continued discussion and amendment of the language proposed. Sincerely, Annajane Yolken Haley McKee Lisa Peterson Co-chairs, SAOPPAC -- Substance Abuse and Overdose Prevention PAC Rhode Island OverdosePreventionPAC@gmail.com overdosepreventionpac.com [overdosepreventionpac.com]	
#11BH	Providence Center Email	 The Providence CENTER hy minds for healthy lives 528 North Main Street Providence, RI 02904 hone:(401) 528-0123 (800) 456-0300 fax:(401) 528-0124 email:info@provctr.org wwvv.;--",rovidencecenter.org October 5, 2018 a member of Care New England Gail Theriauit, Esq. Department of Behavioral Health, Developmental Disabilities and Hospitals BHDDH Office of Legal Counsel	Pages 4,6,9,14, 15



COMMENT #	FROM	COMMENT	RESPONSE Location
		Hazard Building, 41 West Road, Room 241 Cranston, RI 02920 Dear Ms. Theriault: Please find attached written comments from The Providence Center on the proposed regulation "Rules and Regulations for Behavioral Healthcare Organizations" (212R'CR101001). Thank you for your attention to these comments. Sincerely, Deborah M. O'Brien, BS, RN, MPA President and Chief Operating Officer The Providence Center Written Comments October 5, 2018 Comments on Rules and Regulations for Behavioral Healthcare Organizations (212RlCR101001) Thank you for the opportunity to offer comments on these proposed regulations. In summary, The Providence Center is concerned by some important issues in these proposed regulations including an inconsistent approach to required staffing leveis in different types of programs; the potential of the required staffing to add	

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		substantial costs that are currently unfunded; and overiy prescriptive regulations that impinge on physicians' scope of practice, and area governing by other bodies of reguiation. The Providence Center has serious concerns about the regulation's effect of adding to the overall regulatory burden on behavioral healthcare organizations, especially in areas in which the proposed regulations mandate staffing levels. in some cases, the proposed staffing levels would increase costs substantially, putting the viability of programs to treat vulnerable populations very much at risk. To be specific, if these proposed regulations come into effect, The Providence Center will need to reconsider the fiscal viability of programs that offer 63 beds of residential substance use disorder treatment and 98 beds of Mental Health Psychiatric Rehabilitative Residences (also known as Group Homes). Closing these programs would endanger vulnerable populations at a time when the opioid overdose epidemic continues unabated and when options for community living for individuals with serious mental illness are few. We are concerned that these regulations have been developed without input from the groups that pay for the services delivered, particularly insurers. If implemented, one of the effects of these regulations will be that behavioral healthcare organizations will exit, unable to increase revenue to meet the additional costs these regulations impose. The staffing guidelines for Integrated Health Home programs require each IHH team to have one fulltime equivalent Hospital Liaison. With one hospital liaison for every IHH team statewide, this WOUld result in an unmanageable number of liaisons seeking conversations with hospital staff To make this role meaningful, the Department should investigate how the hospital liaison position can be defined in terms to the number of hospitals in the service area or some other factor that will provide consistent points of contact for hospital management. We are concerned that the required staffing levels in the Residential Services section, including the requirement to have a nurse on site 24/7 and to make one-to-one	

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		staffing available when a resident is in crisis in a Mental Health Psychiatric Rehabilitative Residence, and the minimum standard staffing pattern in Residential Programs for Substance Use Disorders, will add costs to the operation of these programs that exceed the revenue available through insurance reimbursement and state contracts. Again, these regulations need to be cross-walked with the requirements of these contracts to avoid unintended sequences and possible program closures. We estimate the minimum staffing required for Residentia\ Programs for SUD treatment will alone bring approximately $500,000 in additional costs to The Providence Center's men's and women's residential treatment programs. This will endanger the sustainability of these programs at a time when the state needs this SUD treatment capacity desperately. These regulations specifying staff composition are problematic because they sometimes conflict with staffing required under contracts with health insurers. We would like to recommend that the Department consult with Medicaid, managed care organizations to reach consensus on the degree of flexibility or prescription desired. Without this agreement, organizations have one set of rules to foliow in regulation and another in the contracts that guide how they are paid. We are also concerned about the regulations uneven approach to mandated staffing levels across these proposed regulations. We believe these proposed regulations are inconsistent in how they address required program staffing. The approaches for prescribing staffing patterns and staffing levels vary widely. As examples: intensive Outpatient Programs the regulations have "an interdiscipbinary team of addiction professionals" staffing the IOP. For partial hospitalization programs, the regulations call for "an interdisciplinary team of credentialed addiction or mental health professionals including counselors, psychologists, social works (sic), and	

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		board-certified physicians" with required staff to patient ratios. For programs for persons with co-occurring mental health and substance related disorders, staff with "the following qualifications are recommended." And the, the regulations prescribe staffing requirements for Integrated Health Home and Assertive Community Treatment programs with little flexibility without prior approval. The Department should take a consistent approach to how it prescribes or recommends staffing for different types of programs. We recommend an approach that provides for the maximum degree of flexibility. Other concerns begin with 13.14, under Definitions, in which the definition of a CMHC or CMHO is focused on an organization that delivers services "within a specific geographic area." Nothing in statute restricts CMHOs from providing services beyond its service area. In response to consumer interest, some groups provide such services in addition to their responsibilities for the assigned geographic area. It would be helpful to have the regulations clarify this point. In 1.6C. Clinical Supervisors, it seems that Licensed Mental Health Counselors (LMHCs) have been left out of the list of licensed independent practitioners who can provide clinical supervision. LMHCs are included in the definition in 1.6.C.1.e, but it would be helpful if they were added to the list in C.I.a. The section 1.6.2 Bio-psychosocial Assessment, Section H requires that "the biopsychosocial assessment shall be rewritten in its entirety every 60 months." This is not compatible with how electronic health records work. In most EHRs, the assessment is not a block of text that gets written and re-written. If this section could be redrafted, it would be heipfui. Section 1.6.7 Outpatient Services and Programs, under point 7 requires that each CMHC and licensed hospital must provide the Department with a list of Qualified Mental Health Professionals (QMHPs) and their supervisors. The first page of these	

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		proposed regulations clarifies that these regulations do not pertain to hospitals. On another important issue, we believe these proposed regulations interfere with the scope of practice for physicians as defined by the Department of Health. Section 1.6.9.5.A 8.b states "a pregnancy test must be given to all women of childbearing age" before medication is prescribed. We do not believe it in the purview of these proposed regulations to require physicians to order any particular medica! test In addition, the requirement to test every women in a broad age range will lead to unnecessary testing. Any test should be undertaken when medicaiiy indicated and taking the input of the patient into consideration. Similarly, this section also requires toxicology screens before medication is prescribed. Services for persons with co-occurring disorders are not the only programs that prescribe medication to individuals who may be pregnant or using substances. This section of the proposed regulations is over-prescriptive, inconsistent with other regulation, and seems to interfere with physicians' scope of practice, an area defined and regulated by other bodies of regulation. Thank you for your attention to all of these issues.	
#12BH	Providence Center Email	Public Comment The Providence Center Owen Heleen, Vice President – Strategy & Grants September 18, 2018 Comments on Rules and Regulations for Behavioral Healthcare Organizations Thank you for the opportunity to offer comments on these proposed regulations. We will submit a fuller set of written comments by the October 6 deadline. The Providence Center is concerned by some important issues in these proposed regulations and the potential of the required staffing to add substantial costs that are currently unfunded.	Pages 4,6,9,14, 15

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#13BH	Providence Center Email	Public Comment The Providence Center Owen Heleen, Vice President – Strategy & Grants September 18, 2018 Comments on Rules and Regulations for Behavioral Healthcare Organizations Thank you for the opportunity to offer comments on these proposed regulations. We will submit a fuller set of written comments by the October 6 deadline.	Pages 4,6,9,14, 15

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		The Providence Center is concerned by some important issues in these proposed regulations and the potential of the required staffing to add substantial costs that are currently unfunded. The Providence Center has serious concerns about the regulations effect of adding to the overall regulatory burden on behavioral healthcare organizations, especially in areas in which the proposed regulations mandate staffing levels. In some cases, the proposed staffing levels would increase costs substantially, putting the viability of programs to treat vulnerable populations very much at risk. We are also concerned about the regulations uneven approach to mandated staffing levels across these proposed regulations. We understand that one of the purposes of regulation is to establish a minimum level of service to protect consumers, but in behavioral health, in most cases, one size does not fit all. We are concerned that these regulations have been developed without input from the groups that pay for the services delivered, particularly insurers. If implemented, one of the effects of these regulations will be that behavioral healthcare organizations will exit, unable to increase revenue to meet the additional costs these regulations impose. Overall, these proposed regulations seem to decrease the regulatory burden on the Department while increasing the burden on organizations. Our concerns begin with 1.3.14, under Definitions, in which the definition of a CMHC or CMHO is focused on an organization that delivers services "within a specific geographic area." Nothing in statute restricts CMHOs from providing services beyond its service area. In response to consumer interest, some groups provide such services in addition to their responsibilities for the assigned geographic area. It would be helpful to have the regulations clarify this point. In 1.6C. Clinical Supervisors, it seems that Licensed Mental Health Counselors (LMHCs) have been left out of the list of licensed independent practitioners who can provide clinical supervision. LMHCs are included in the definition in 1.6.C.1.e, but it would be helpful if they were added to the list in C.1.a. The section 1.6.2 Bio-psychosocial Assessment, Section H requires that "the biopsychosocial assessment shall be rewritten in its entirety every 60 months." This is not compatible with how electronic health records work. In	

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		most EHRs, the assessment is not a block of text that gets written and re-written. If this section could be redrafted, it would be helpful. Section 1.6.7 Outpatient Services and Programs, under point 7 requires that each CMHC and licensed hospital must provide the Department with a list of Qualified Mental Health Professionals (QMHPs) and their supervisors. The first page of these proposed regulations clarifies that these regulations do not pertain to hospitals. We believe these proposed regulations are inconsistent in how they address required program staffing. The approaches for prescribing staffing patterns and staffing levels vary widely. As examples: Intensive Outpatient Programs the regulations have “an interdisciplinary team of addiction professionals” staffing the IOP. For partial hospitalization programs, the regulations call for “an interdisciplinary team of credentialed addiction or mental health professionals including counselors, psychologists, social works (sic), and board-certified physicians” with required staff to patient ratios. For programs for persons with co-occurring mental health and substance related disorders, staff with “the following qualifications are recommended.” And the, the regulations prescribe staffing requirements for Integrated Health Home and Assertive Community Treatment programs with little flexibility without prior approval. The Department should take a consistent approach to how it prescribes or recommends staffing for different types of programs. We recommend an approach that provides for the maximum degree of flexibility. These regulations specifying staff composition are problematic because they sometimes conflict with staffing required under contracts with health insurers. We would like to recommend that the Department consult with Medicaid managed care organizations to reach consensus on the degree of flexibility or prescription desired. Without this agreement, organizations have one set of rules to follow in regulation and another in the contracts that guide how they are paid. On another issue, in one occasion, we believe these proposed regulations interfere with the scope of practice for physicians as defined by the Department of Health. Section 1.6.9.5.A 8.b states “a pregnancy test must be given to all women of childbearing age.” We do not believe it in the purview of these proposed regulations to require physicians to order any	

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		particular medical test. In addition, the requirement to test every women in a broad age range will lead to unnecessary testing. Any test should be undertaken when medically indicated and taking the input of the patient into consideration. The staffing guidelines for Integrated Health Home programs require each IHH team to have one full-time equivalent Hospital Liaison. With one hospital liaison for every IHH team statewide, this would result in an unmanageable number of hospital liaisons seeking conversations with hospital staff. To make this role meaningful, the Department should investigate how the hospital liaison position can be defined in terms to the number of hospitals in the service area or some other factor that will provide consistent points of contact for hospital management. We are concerned that the required staffing levels in the Residential Services section, including the requirement to have a nurse on site 24/7 and to make one-to-one staffing available when a resident is in crisis in a Mental Health Psychiatric Rehabilitative Residence, and the minimum standard staffing pattern in Residential Programs for Substance Use Disorders, will add costs to the operation of these programs that exceed the revenue available through insurance reimbursement and state contracts. Again, these regulations need to be cross-walked with the requirements of these contracts to avoid unintended sequences and possible program closures. We estimate the minimum staffing required for Residential Programs for SUD treatment will alone bring approximately $500,000 in additional costs to The Providence Center's men's and women's residential treatment programs. This will endanger the sustainability of these programs at a time when the state needs this SUD treatment capacity desperately. Thank you for your attention to all of these issues.	