Dixon, Lisa (ANF)

From: Vic DiGravio <vdigravio@abhmass.org>
Sent: Thursday, January 14, 2016 12:41 PM
To: Sudders, Marylou (EHS)
Cc: Lepore, Kristen (ANF); Tsai, Daniel (EHS); Mikula, Joan (DMH); Bharel, Monica (DPH); Spears, Linda (DCF); Dixon, Lisa (ANF); Darcy, Leslie (EHS); agilman@abhmass.org
Subject: ABH recommendations for regulatory review process
Attachments: ABH Letter Baker Administration Regulatory Review 1.14.16 Final.pdf; ABH Memo Regulatory Review Recommendations 1.14.16.pdf; ABH Regulatory Recommendations Expand Access to Treatment 1.11.16.pdf; ABH MassHealth Reg Recommendations on Integration Final 10.15.pdf

Importance: High

Madame Secretary,

Please find attached a series of documents representing the recommendations of ABH members relating to reform of state regulations. Attached are the following:

1. Cover letter outlining general recommendations for regulatory reform
2. A document providing existing regulations, including citations accompanied by specific recommendations for regulatory relief
3. A document specific to regulatory reforms that will help increase access to addiction treatment
4. A document specific to regulatory reforms that will facilitate integration of primary and behavioral healthcare (This document was previously submitted to MassHealth in October 2015).

As always, ABH and are members are available to answer any questions you or your staff may have about these materials.

Thank you.

Vic

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FOR BEHAVIORAL
HEALTHCARE

January 14, 2016

Secretary Marylou Sudders
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Dear Secretary Sudders:

On behalf of the members of the Association for Behavioral Healthcare, we are submitting the following recommendations following Executive Order #562 which outlined Governor Baker's commitment that his Administration would undertake a review of all state regulations currently under its jurisdiction and only retain those regulations which are mandated by law or essential to the health, safety, environment or welfare of the Commonwealth.

As you know, the Association for Behavioral Healthcare (ABH) is a statewide association representing more than eighty community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people.

ABH member organizations appreciate the Governor's willingness to address burdensome, duplicative regulations which make it more difficult for mental health and addiction treatment organizations to provide high-quality services to some of the Commonwealth's most vulnerable citizens.

This cover letter addresses general issues of particular interest to ABH members that could reduce administrative inefficiencies and decrease the burden on behavioral health providers serving individuals in the Commonwealth. Attached to this document are more detailed documents outlining our specific requests for regulatory changes including citations and proposed language.

Expansion or Relocation of Existing Programs

ABH members experience numerous administrative hurdles and lengthy timelines when they are preparing to open new program sites and/or relocate existing services, regardless of the provider organization's history of providing these types of services. ABH recommends a streamlined and expedited process through the Department of Public Health (DPH) for providers expanding existing services to new service sites or for providers simply moving the location of an existing program.

ABH members understand the need to work with DPH regulators on the physical aspects of the new facility, but believe the lengthy record submissions on staffing patterns, policies, and information on programming is duplicative and should be eliminated if DPH already has such information on file for the provider organization. DPH requires providers to submit this

information even if the existing outpatient or day treatment program is moving from one building to another. Essentially, it is treated as an application for an entirely new program. Providers are also required to submit this duplicative information anytime they are opening an additional outpatient site, and DPH already has extensive information about the same types of programs.

The same duplication of efforts exists when providers add additional outpatient clinics with MassHealth. Providers who already serve clients in the outpatient setting that are looking to expand services to a new location are treated as first time applicants and have to submit large amounts of paperwork and information regardless of their history and current status with MassHealth.

Background Checks

Providers continue to struggle to navigate the woefully underfunded background check system in order to hire employees for their programs. We strongly support and understand the need to complete thorough checks on all employees as they serve the Commonwealth's most vulnerable citizens, but it is imperative the Administration address the four to eight week time line it currently takes to complete the process. According to EEC regulations (606 CMR 14.00), EEC's Background Record Check process consists of three initial checks: a Criminal Offender Record Information (CORI) check, a check of the Department of Children and Families' (DCF) Central Registry and Registry of Alleged Perpetrators, and a Sex Offender Registry Information (SORI) check. After review and approval of these three checks, a fingerprint-based check of the state and federal criminal history databases must then be completed.

Agencies are losing many qualified candidates who are not willing to wait that long to begin employment. Additionally, agencies must use overtime or temporary relief staff to cover these positions until these new staff members may be hired, which is not the best practice for the clients served by the agency.

Virtual Gateway

Providers serving clients across EOHHS agencies are required to use the Virtual Gateway to submit data to EOHHS. The theory behind this is that this will allow for greater shared communication, treatment planning, and support for clients and families. In reality, though, not all case managers and team members (including internal to EOHHS agencies) have access to the Virtual Gateway. Use of the Virtual Gateway continues to be problematic for providers as it results in duplication of efforts on multiple fronts (CANS, critical incident reporting, treatment plans) where agencies rely on paper records or their own Electronic Health Record system and then must enter data through the Virtual Gateway portal. The Virtual Gateway forms are not user friendly, have space limitations that do not meet the requirements of all contracts, do not have target areas for all required information making them very difficult to use.

Medication Administration Program (MAP)
105 CMR 700.003 (F) & sub-regulatory guidance

ABH continues to be concerned regarding the significant issues surrounding the Medication Administration Program (MAP) overseen by the Department of Public Health (DPH) and administered across EOHHS programs. We believe that a fuller review of the program in

collaboration with the providers who are implementing it is essential to ensure the program is successful and ensures the safety of the clients ABH members and other providers serve.

Standardization and Eliminating Duplicity across EOHHS Agencies

Incident Reporting

ABH encourages EOHHS to address the inconsistencies that exist across agencies with the incident reporting process. Providers contract to provide services across EOHHS agencies and it is difficult for these providers to implement vastly different processes in multiple programs as required by different EOHHS agencies. Consistency in the information the provider needs to report as well as the mechanism for reporting would save valuable time and resources.

Investigations by EOHHS Agencies

EOHHS agencies often have different investigation protocols which can be challenging to providers that contract with multiple agencies. Varying protocols result in varying quality in terms of investigations by state agencies.

Additionally, EOHHS agencies often do not even follow their own protocols. Many fail to complete investigations according to the required timelines set forth in their own regulations. Delayed investigations are not in the best interest of the Commonwealth, provider organizations and most importantly, individuals being served.

ABH recommends that EOHHS convene state agencies and providers to identify best investigatory practices across the Secretariat and then implement a standardized investigation protocol to be implemented by all EOHHS agencies.

Room & Board Charges
1054 CMR 30.06 & 115 CMR 3.05

Charges for care (room and board, program fees, etc) differ across EOHHS agencies adding an administrative burden to providers to maintain different systems to calculate and track charges for different clients. Standardization would also benefit the individuals served across agencies as some are required to pay more than others for the same service.

Consistency of Water Temperature Code
Licensing Indicator Guidelines: DDS L15: DMH s410.190

As ABH members serve individuals across multiple residential programs, it would remove an administrative burden to programs if DMH and DDS had consistent water temperature codes across residential programs.

Not-for-Profit Contractor Surplus Revenue Retention
808 CMR 1.03 (7)

This regulation limits ABH members to a 5% annual cap on revenue and a cumulative amount that may not exceed 20%. This regulation jeopardizes the availability of providers to meet major infrastructure needs, penalizes long-term providers that have strong, consistent management and

treats for-profit firms more favorably than nonprofit providers that in many cases may be doing similar work.

Regulatory Barriers to Integration of Primary and Behavioral Healthcare

ABH previously submitted specific recommendations (please see attached) to MassHealth regarding removing barriers to integration, particularly focused on the regulations governing Mental Health Outreach Programs (130 CMR 429). ABH recommends that the Administration examine those recommendations along with addressing the corresponding DMH clinic licensure regulations 105 CMR 140.560. These sets of regulations are archaic in a time of integrated care and make it difficult to operate co-located programs and satellite clinics that interact with other parts of the health care system.

Some of the DPH outpatient mental health clinic regulations we have included in this document relate to documentation. ABH members are particularly concerned about how these requirements create barriers to integrated care. ABH members have formed a workgroup that plans to submit recommendations to MassHealth specifically about how documentation requirements could be restructured to better support integrated services.

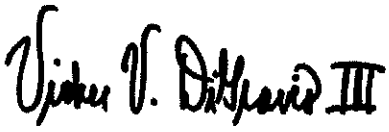
Expanding Access to Addiction Treatment

ABH is grateful to both Governor Baker and you for your leadership in promoting solutions to the current opioid epidemic we are facing in Massachusetts. The Governor and EOHHS have offered a number of thoughtful recommendations to date in terms or prevention, early intervention and treatment, including funding to enhance existing services and creation of new programs.

ABH has compiled a list of regulatory changes that we believe will expand access to services in this time of crisis. We have attached these recommendations as a separate document for your consideration.

Thank you for your consideration of these recommendations. Feel free to contact me at 508-647-8385 x11 or vdigravio@abhmass.org if you have any questions or we can be of further assistance.

Sincerely,



Vicker V. DiGravio III
President/CEO

Enclosure (3)

CC: Secretary Kristen LePore, Secretary, Executive Office of Administration and Finance
Assistant Secretary Daniel Tsai, MassHealth
Commissioner Joan Mikula, Department of Mental Health
Commissioner Monica Bharel, Department of Public Health
Commissioner Linda Spears, Department of Children and Families

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Submitted to MassHealth Previously October 2015

MassHealth Regulatory Barriers
Integration of Behavioral Health and Primary Health Care
ABH Recommendations

MASSHEALTH COMMUNITY MENTAL HEALTH CENTER (CMHC)
REGULATIONS 130 CMR 429

1. **OUTREACH PROGRAM and CASE CONSULTATION DEFINITIONS**

429.402: Definitions

- ***Outreach Program*** *— a mental-health-center program located off the premises of the mental health center that:*
  - ***(2)*** *is open to patients* ***no more than 20 hours per week****; and*
  - *(3) on a regular basis offers* ***no more than 40 staff hours per week*** *of mental health Services*

ABH Recommendations

Change the definition statement to read as follows: "**Outreach Program** — a mental-health-center program located off the premises of the mental health center **that delivers outreach behavioral health services in partnership with health care providers, school systems, and other systems as needed or requested."**

Also, **eliminate 429.402, #(2) and (3),** as these limitations on the number of hours of services severely limit CMHCs' capacity to deliver a sufficient amount of behavioral health outreach services.

- ***Case Consultation*** *— environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions which may include the preparation of reports of the patient's psychiatric status, history, treatment, or progress (other than for legal purposes) for other physicians, agencies, or insurance carriers.*

ABH Recommendation

Change this definition statement to read as follows: "**Case Consultation —** environmental intervention for **behavioral** and medical management purposes **on a patient's behalf with staff,** other agencies, employers, or institutions which may include the preparation of reports of the patient's psychiatric status, history, treatment, or progress (other than for legal purposes) for other **staff,** physicians, agencies, or insurance carriers.

The word "psychiatric" was also removed from this definition as CMHCs also serve individuals with substance use disorders.

2. CASE CONSULTATION

429.421: Scope of Services

(A) Requirements. (1)(B)(10)

(1) A mental health center must have services available to treat a wide range of mental and emotional disorders, and it must provide comprehensive diagnostic assessments for a wide range of problems. In certain rare circumstances, the MassHealth agency may waive the requirement that the center directly provide one or more of these services if the center has a written referral agreement with another source of care to provide such services, and makes such referrals according to the provisions of 130 CMR 429.411.

(B) Diagnostic and Treatment Services. A center must have the capacity to provide at least the following diagnostic and treatment services, as defined in 130 CMR 429.402:

(10) case consultation; ***Case consultation must consist of a scheduled meeting between the clinical staff at the mental health center and other providers of treatment concerning a member who is a center's client. Other providers of treatment are professional staff who are not employed by the mental health center,*** *but who are actively providing care or treatment for the member, including professional staff providing services on behalf of an employer. The purpose of case consultation must include at least one of the following:*

(a) identifying and planning for additional services;

(b) coordinating a treatment plan with other providers involved in the member's care;

(c) reviewing the member's progress; or

(d) revising the treatment plan as required.

ABH Recommendation

Revise (1)(B)(10) to read as follows: "(10) case consultation; Case consultation must consist of a scheduled meeting between the clinical staff at the mental health center and other providers of treatment concerning a member who is a center's client. **Other providers of treatment include professional staff within or outside of the mental health center,** but who are actively providing care or treatment for the member, including professional staff providing services on behalf of an employer."

3. CMHC BILLABLE STAFF

429.424: Qualifications of Professional Staff Authorized to Render Billable Mental Health Center Services by Core Discipline

(A) Psychiatrist.

(B) Psychologist.

(C) Social Worker.

(D) Psychiatric Nurse.

(E) Psychiatric Nurse Mental Health Clinical Specialist.

(F) Counselor.

(G) Occupational Therapist.

ABH Recommendation

Add physicians and Advanced Practice/Nurse Practitioners to the list of CMHC Billable Staff so they may render limited physical health examinations and services within the structure of the CMHC.

4. **CMHC MEDICAL CARE**

429.433: Coordination of Medical Care

A mental health center must ***coordinate psychotherapeutic treatment with medical care for MassHealth members.*** *If a member has not received a physical exam within six months of the date of intake, the mental health center must advise the member that one is needed. If the member does not have an existing relationship with a physician, the mental health center must assist the member in contacting the MassHealth agency's customer service toll-free line to receive help in selecting a physician. If the member does not want a physical examination, the member's record must document the member's preference and any stated reason for that preference.*

ABH Recommendation

Expand the opening statement to read, "A mental health center must coordinate psychotherapeutic treatment and may provide physical health examinations as part of care coordination with primary health care providers for MassHealth members."

5. **OUTREACH PROGRAMS**

429.440: Outreach Programs

An outreach program operated by a mental health center is eligible for payment if it meets the standards described in 130 CMR 429.440(A) through (G).

(A) Outreach program staff members must receive supervision and in-service training in accordance with the requirements specified in 130 CMR 429.438(E). (**NOTE**: re supervision)

(B) The director of clinical services must meet at least on a monthly basis with outreach program staff members and have direct contact with outreach program clients as necessary to provide medical diagnosis, evaluation, and treatment in accordance with the requirements outlined in 130 CMR 429.423(B). (**NOTE:** re Director of Clinical Services)

(C) Outreach programs must maintain the records of their clients on the premises of the parent center.

(D) Outreach programs must be subject to all written policies and procedures of the parent center governing the kinds of services that the outreach program offers.

(E) Outreach programs must meet the requirements of 130 CMR 429.439(D) applicable to dependent satellite programs. (**NOTE:** re satellite program services – **see ABH Recommendation #7 below**)

(F) Outreach program services must conform to the definition in 130 CMR 429.402. (**NOTE:** re definition of outreach program, see #1 above)

*(G) Services provided at outreach programs are subject to the requirements in 130 CMR 429.431 (***NOTE:** re Operating Procedures*), 429.432* (**NOTE:** re MDT), *and 429.435* (**NOTE:** re UR Plan, **see ABH Recommendation #8 below**)

6. **SERVICE LIMITATIONS**

429.441: Service Limitations

(C) Case Consultation.

(1) The MassHealth agency pays only for a case consultation that involves a personal meeting with a professional ***of another agency.***

ABH Recommendation

Remove the words "of another agency" from 429.441 (C) (1)

7. **SATELLITE PROGRAMS**

429.439: Satellite Programs

Services provided by a satellite program are reimbursable only if the program meets the standards described below.

(D) If a dependent satellite program does not offer the entire range of services available at the parent center, the dependent satellite program must refer clients to the parent center or a facility that offers such services. The parent center must determine the necessity for treatment and ***the appropriateness of the treatment plan*** *for such clients and institute a clear mechanism through which this responsibility is discharged, by consultation with the satellite program team, regular supervision of the satellite program by supervisory-level professional core staff in the parent center, or by other appropriate means. For staff composition requirements pertaining to dependent satellite programs, see 130 CMR 429.422(D).*

ABH Recommendation

For Outreach Program requirements, it is important to remove the requirement that they must develop a treatment plan that *complies with DPH regulations at 105 CMR 140.520 (C),* as they require the development of a compressive assessment and treatment plan for each patient.

Also see *130 CMR 429.432:* *Treatment Planning and Case Review (A)* which states that *The multidisciplinary team must conduct case review according to the DPH regulations at 105 CMR 140.540;* ***must prepare a treatment plan that complies with DPH regulations at 105 CMR 140.520(C);*** *and must establish criteria for determining when termination of treatment is appropriate.*

Instead, add the requirement that "Outreach service providers must conduct brief evaluations for mental health and addiction treatment services and make referrals (triage) to behavioral healthcare services as needed."

8. **UTILIZATION REVIEW PLAN**

429.435: Utilization Review Plan

The mental health center must have a utilization review plan that meets the following conditions.

(A) A utilization review committee must be formed, composed of the clinical director (or his or her designee) and two other professional staff members who meet all the qualifications for their discipline, as outlined in 130 CMR 429.424.

(B) The utilization review committee ***must review each of the center's cases*** *in accordance with the Department of Public Health regulations found at 105 CMR 140.540 and following the member's termination.*

ABH Recommendation

This requirement needs to be revised to accommodate the services provided by an Outreach Program. The utilization review of each outreach patient that has been screened is excessive for the brief evaluation conducted. This UR requirement should be reserved only for those patients that are referred to the CMHC for treatment.

SUBSTANCE ABUSE TREATMENT
MassHealth Regulations 130 CMR 418

1. **SCOPE OF SERVICES**

418.405: Scope of Services

The Division pays only for the following services furnished by substance abuse treatment programs, in accordance with the regulations of the Massachusetts Department of Public Health at 105 CMR 160.000, 161.000, 162.000, and 750.000:
(A) the following services provided by freestanding methadone treatment programs, including methadone detoxification and methadone maintenance programs:
(1) the administration and dispensing of methadone; and
(2) individual, group, and family/couple counseling;

ABH Recommendation

Include in 418.405 (A) (1) "and other FDA approved medications for the treatment of opioid addiction."

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ABH Regulatory Recommendations to Expand Access to Addiction Treatment

As the Baker Administration reviews regulations across EOHHS, ABH recommends the following changes to expand access to addiction treatment services during the opioid epidemic.

MASSHEALTH SUBSTANCE ABUSE TREATMENT REGULATIONS 130 CMR 418

Recommendations to address the state's Opioid Epidemic by allowing licensed Opioid Treatment Programs (OTPs) to administer all FDA-approved medications for the treatment of opioid addiction.

1. SCOPE OF SERVICES

Currently Reads As:

130 CMR 418.405: Scope of Services

The Division pays only for the following services furnished by substance abuse treatment programs, in accordance with the regulations of the Massachusetts Department of Public Health at 105 CMR 160.000, 161.000, 162.000, and 750.000:

(A) the following services provided by freestanding methadone treatment programs, including methadone detoxification and methadone maintenance programs:

(1) the administration and dispensing of methadone; and

(2) individual, group, and family/couple counseling;

ABH Recommendation

Include in 418.405 (A) (1) "and other FDA approved medications for the treatment of opioid addiction."

2. Revise EOHHS 101 CMR 317.00 Medicine Rate Regulations

Currently Reads As:

101 CMR 317.02 General Definitions

Eligible Provider: *A licensed physician or licensed osteopath, licensed podiatrist, licensed optometrist, ...*

A provider of radiation oncology services.....

A clinic licensed by the Massachusetts Department of Public Health in accordance with regulations 105 CMR 140.000: Licensure of Clinics to provide medical diagnostic services.

ABH Recommendation

Amend these regulations to include "A program licensed by the Massachusetts Department of Public Health in accordance with regulations 105 CMR 164.300 for Opioid Treatment." OTPs could then bill for the delivery of buprenorphine and naltrexone and individual and group counseling services under the Medicine Rate Non-Facility Activity Codes (NFAC) as follows:

Code	NFAC	FAC	Global Fee	PC Fee	TC Fee	Description
90832	48.53	37.26				Psychotherapy, 30 minutes with patient and/or family member
90834	61.81	55.89				Psychotherapy, 45 minutes with patient and/or family member
90853	23.76	21.81				Group psychotherapy (other than of a multiple-family group)
99211	15.41	6.77				Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99213	52.37	36.21				Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214	77.46	55.72				Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

3. **Clinical Laboratory Services Billing**

OTPs or their contracted laboratories will bill for toxicological screenings under 114.3 CMR 20.00: Clinical Laboratory Services, as follows:

G0431		$ 48.78			Drug screen, qualitative; multiple drug classes by high complexity test method (eg, immunoassay, enzyme assay), per patient encounter

MASSHEALTH PROVIDER MANUAL SERIES
SUBSTANCE ABUSE TREATMENT MANUAL 130 CMR 418.000

Recommendations to align MassHealth regulations with the DPH/BSAS licensing regulations 105 CMR 164.

1. ***418.404: Provider Eligibility***

Currently Reads As:

Payment for services described in 130 CMR 418.000 will be made only to providers of substance abuse treatment services who are participating in MassHealth on the date of service. The eligibility requirements for providers of substance abuse treatment services are as follows.

(A) In State. The following requirements apply when the provider is located in Massachusetts.
(1) Methadone Treatment Program. *A provider who furnishes methadone detoxification and methadone maintenance services must be licensed as a methadone treatment program by the Massachusetts Department of Public Health under its regulations at 105 CMR 750.000.*
(2) Acute Inpatient Substance Abuse Treatment Services. *A provider who furnishes acute inpatient substance abuse treatment services must be licensed or approved, or both, as a provider of acute inpatient substance abuse treatment services by the Massachusetts*
Department of Public Health pursuant to its regulations at 105 CMR 160.000 and 161.000.
(3) Substance Abuse Outpatient Counseling Program. *A provider who furnishes substance abuse outpatient counseling services must be licensed by the Massachusetts Department of Public Health to provide such services under its regulations at 105 CMR 162.000. These services include counseling services and acupuncture detoxification.*
(4) Special Services for Pregnant Members. *A provider who furnishes intensive outpatient, day treatment, or case management services must be approved by the Massachusetts Department of Public Health to provide each of those services under its regulations at 105CMR 162.000. A provider who furnishes enhanced acute inpatient substance abuse treatment services must be approved by the Massachusetts Department of Public Health to provide such services under its regulations at 105 CMR 160.000 and 161.000.*

In addition, at *418.405 Scope of Services* and *418.411 Special Services for Pregnant Recipients: Service Limitations*, the regulations further specify treatment services for Pregnant Women as follows:

(A) Eligibility Period

(B) Case Management

(C) Intensive Outpatient Program

(D) Day Treatment Program

ABH Recommendation
Case Management, Intensive Outpatient and Day Treatment services are not limited solely to *Pregnant Recipients*. DPH and MassHealth payers purchase these services for non-pregnant women, men and adolescents. ABH recommends that MassHealth include these as service options available to the larger MassHealth member population in 418.404: Provider Eligibility

2. 418.406: Service Limitations
Currently Reads As:
(C) Substance Abuse Outpatient Counseling Programs.
(2) Case Consultation.
(a) The Division will pay a provider only for case consultation that lasts at least 30 minutes. Payment is limited to a maximum of one hour per session, once every three months.

ABH Recommendation

ABH recommends that the statement *once every three months* be deleted. DPH licensure regulations do not limit the number or frequency of consultations. More consultations may be needed for some patients, in order for the providers to deliver coordinated, quality care.

3. **418.411: Special Services for Pregnant Recipients: Service Limitations**

Currently Reads As:

(D) Day Treatment Program. Under the day treatment program, payment for individual counseling is limited to 47 hours per eligibility period per recipient. Payment for family/couple counseling is limited to 26 hours per eligibility period per recipient. Payment for day treatment is limited to 235 days. Case management services as described in 130 CMR 418.410(C) must be provided as a component of day treatment and are included in the day treatment rate (see 130 CMR 418.411(B)(2)). The Division will not pay for the following services while the recipient is receiving day treatment services:

(1) methadone counseling;

ABH Recommendation

ABH recommends that the number of counseling hours allowed *per eligibility period per pregnant recipient* and *couple/family* be increased to align with current practice standards and the special needs of individual clients.

In addition, ABH requests that (D) (1) *methadone counseling*, be removed as an exclusion. If a client is enrolled in a day treatment program and also receiving methadone from an OTP-licensed clinic, the OTP should also be able to provide counseling services as needed by the client. ABH requests that this exception be removed from 418.411.

DPH/BSAS 105 CMR 164
OPIOID TREATMENT PROGRAMS

1. **105 CMR 164.302 Provision of Services – All Opioid Treatment Programs**

Currently Reads As:

(C) Physical Examination: The licensee shall ensure that each client has a physical examination by a physician, or by a qualified health-care professional under the supervision of a program physician prior to administration of the first dose of medication. The examination shall include:

(1) an assessment of the patient's substance use disorder;
(2) a brief mental status exam;
(3) tests for the presence of opiates, alcohol, benzodiazepines, cocaine and other drugs of abuse as indicated by the patient's current substance use history.
(4) an assessment of the possibility of: infectious diseases, including HIV, TB, Viral Hepatitis and sexually transmitted diseases; pulmonary, liver, and cardiac abnormalities; dermatological and neurological sequelae of addiction; and possible concurrent surgical problems. The assessment shall include the following laboratory tests, results of which must be returned no later than 14 days after admission:

(a) tests to determine liver function;
(b) tests to screen for anemia, coronary risk factors; and
(c) complete blood count and differential blood tests.

The licensee shall ensure that such laboratory tests are completed by licensed facilities which comply with all applicable federal and state laboratory licensure and certification requirements

ABH Recommendation

Admission to the OTP from other levels of care could be expedited if they were allowed to accept a physical examination report from other levels of care, instead of making a client wait for an appointment with an OTP physician or qualified health-care professional for a physical examination prior to admission.

ABH recommends that the physical examination requirements for OTPs mirror the requirements by DPH for other levels of care. For example, at *105 CMR 164.422: Provision of Services,* it states:

(E) Medical Services: The licensee shall refer the client for a complete physical examination within 30 days of admission unless medical reports document a comparable examination within 12 months prior to admission. Referrals shall be documented in the client's record.

DEPARTMENT OF PUBLIC HEALTH
105 CMR 164.000 LICENSURE OF SUBSTANCE ABUSE TREATMENT PROGRAMS

1. 164.082: Special Populations (B) Persons under 18 Years of Age

Currently Reads As

(B) Persons Under 18 Years of Age: Licensees serving persons under 18 years of age shall:

...

(5) ensure that adolescents are served in programs which are separate from programs serving adult populations; and
(6) prior to providing any services to persons under 18, inform the Department of the nature and scope of any services provided to adults in the same facility as those intended for services for adolescents. The Department shall determine whether such proximity of adult services constitutes a risk to adolescents.

ABH Recommendation

All licensees must meet the requirements outlined above to serve individuals under 18 years of age. Although we understand the need to separate these populations in more intense 24 hour levels of care, ABH recommends that outpatient providers are given more flexibility to serve both adults and children. In particular, the need to inform DPH when serving those under 18 years of age in the same facility as adults is a burden to providers and limits care to a population who need access to treatment.

2. 164.232: Day Treatment, Provision of Services

Currently Reads As:

(C) Treatment: The licensee shall provide each client with:

(1) 3½ hours of services each day, five days per week. Such service program shall meet the requirements of 105 CMR 164.074: Minimum Treatment Service Requirements and also include counseling, psychoeducational groups, and family counseling; and,

ABH Recommendation

Increase the number of units of service that BSAS procures from one - 3½ hour unit to two units per day. Day Treatment, as licensed by BSAS, is also called Structured Outpatient Addiction Treatment (SOAP) and all of the MassHealth MCEs and the Massachusetts Behavioral Health Partnership authorize and pay for two - 3½ hour units per day. Since BSAS only purchases this service for uninsured clients, and the Day Treatment providers never bill out their BSAS contracted funding for this service, ABH recommends that this regulation be changed so that BSAS will pay for two - 3½ hour units per day for uninsured clients, as they are often homeless and would be better served if they could remain in a day treatment environment for two - 3½ hour units per day.

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ABH Regulatory Recommendations following Governor Baker Executive Order #562

Department of Mental Health
104 CMR 28.00 Licensing and Operational Standards for Community Programs

1. 28.13: Licensing: General Provisions

(1) Programs Subject to Licensure. A program is required to obtain a license or licenses as follows:
(a) Residential Site License. A site license is required for each residential site a program operates. A residential site is a site at which one or more clients reside, or are provided with sleeping accommodations, and in which the program has a direct or indirect ownership interest, or which the program leases or co-leases. ***If a program is a guarantor of a client's residential lease, the program is not required to obtain a residential site license for the leased property; provided, however, the program director shall provide the Area Director or designee with a letter attesting that the leased property meets applicable health, safety and fire codes. The Department may require a site inspection, providing good cause exists, to assess the general condition of the residence or unit.***

ABH Recommendation:
The Department of Mental Health licensing requirements, stipulate that an individual receiving a DMH Rental Subsidy must have their lease signed by the provider agency. This in turn results in a DMH licensing visit which is excessive from the landlord's point of view. In addition, it subjects the individual served who happens to have a DMH Rental Subsidy to a set of requirements with which other individuals, who receive federal housing subsidies, do not need to comply. The licensing of leased apartment may result in deficiencies, many of which exceed local housing standards, and must be remedied by the landlord. This increases their financial burden to house a DMH client and reduces their willingness to rent to DMH-connected individuals in future.

Department of Public Health – Mental Health Clinic Licensure
105 CMR 140.000: Licensure of Clinics

1. 140.103: Other Licensing Requirements

(E) Submission and Approval of Plans. In the case of new construction of a clinic or any satellite clinic, or in the case of alterations or additions to an existing clinic or any satellite clinic, preliminary architectural plans and final architectural plans and specifications shall be submitted to the Commissioner. Written approval of the Commissioner shall be obtained prior to said new construction or alterations or additions. Standards for review and approval of plans shall be established as administrative guidelines by the Department, ***based on the Facility Guidelines Institute's Guidelines for Design and Construction of Health Care Facilities****. In the case of a clinic that provides mobile medical services, plans for siting at each host location shall be submitted by the clinic or the host location.*

ABH Recommendation
DPH is currently requiring licensed mental health clinics and day treatment providers to fulfill the FGI Guidelines for more complex facilities like Outpatient Psychiatric Centers (OP13) and Outpatient Rehabilitation Therapy Facilities (OP14). The level of service provided in an outpatient mental health clinic most closely aligns with the FGI Guidelines outlined in the Mental Health Counseling Clinics (OP12) checklist. ABH recommends the regulations be amended to include a requirement that mental health clinics must meet these OP12 facility standards to operate. Sections of the OP13 checklist include nurse and staff stations, requirements for nourishment areas and soiled holding rooms which are not necessary for an outpatient mental health clinic.

2. 140.520: Adequate Mental Health Services

140.520 (B): Evaluation and Diagnostic Services

> *(1) Evaluation and diagnostic services must be documented and shall include an assessment made to determine the patient's physical health, psychological, social, economic, educational, functional or development status, vocational assets and disabilities, and a comprehensive drug history. The assessment shall be conducted by appropriate professional* ***health care providers****.*
> *(2) When the initial evaluation indicates further assessment, the clinic program must conduct or make arrangements for necessary testing, physical examination and/or consultation by qualified mental health and/ or medical professionals. (3) When appropriate, a diagnostic evaluation shall include the finding of a formal mental status examination and a diagnosis. (4) A diagnostic evaluation as defined in 105 CMR 140.520(B)(1) through (3) must be completed before a treatment plan is developed.*

ABH Recommendation
1.) Elsewhere the term mental health professional is used and it is unclear why this wording in clause (1) says provided by a "health care" provider. Add "mental" before "health".

2.) Many urgent, one time, short term interventions, do not require a "A Diagnostic evaluation as defined in 105 CMR 140.520(B)(1) through (3)" which is quite lengthy. Evaluations should be appropriate to the complaint and what clients want help with. This situation is quite common in medical practices where the "treatment plan" might be very brief and focused on a specific problem. In addition, in an age of integration where behavioral health providers are working in medical practices, a full evaluation may not be appropriate. ABH recommends substituting "an evaluation appropriate to the client's chief complaint or problem" and striking "as defined in 105 CMR 140.520(B)(1) through (3)"

Department of Public Health – Bureau of Substance Abuse Services
105 CMR 164.000: Licensure of Substance Abuse Treatment Programs

1. **Individual treatment plan**

164.073: Individual Treatment Plan

(B) The licensee shall ensure that individual treatment plans are reviewed with the client and amended as necessary. When treatment continues for three months or more, treatment plans shall be reviewed at least once every three months. The client and staff reviewing the plan shall sign it, and it shall be incorporated into the client's record. If there has been no client contact over a three-month period, the client shall be discharged from care and the case closed.

ABH Recommendation
Change the timeframe required for the review of treatment plans from three months, to "**as necessary but at least once a year**". This mirrors the current requirement for Mental Health Centers under 105 CMR 140.540 (D)

2. **Training and Supervision**

164.044: Training and Supervision

ABH Recommendation
BSAS training requirements are important for provider staff, but can be onerous to complete, particularly as providers are required to backfill positions for extended periods of time, including the time it takes staff to travel to training. ABH recommends BSAS work with its training vendor to develop online training modules for provider staff to complete. This could be done similar to the online safety training course developed by EOHHS in 2013.

Opioid Treatment Programs

1. **Amend 105 CMR 164.073 (B) Individual Treatment Plan**
   Currently Reads As:
   (B) The licensee shall ensure that individual treatment plans are reviewed with the client and amended as necessary. When treatment continues for three months or more, treatment plans shall be reviewed at least once every three months. The client and staff reviewing the plan shall sign it, and it shall be incorporated into the client's record. If there has been no client contact over a three-month period, the client shall be discharged from care and the case closed.

   ABH Recommendation
   ABH recommends inserting after the 3rd sentence: "When treatment continues for one (1) year, treatment plans shall be reviewed every six months; and when treatment continues for five (5) years, treatment plans shall be reviewed at least annually."

2. **DPH Proposed Amendment to 105 CMR: 164.075 Termination and Discharge**
   Current DPH proposal for new regulatory language is as follows:
   (4) Procedures for determining, in consultation with the client, referrals needed to ensure a continuum of care, reduction of risk of relapse, and reduction of risks to client's well-being, including referrals to:
   - *(a) certified alcohol and drug-free housing;*
   - *(b) additional substance use disorder treatment;*
   - *(c) treatment of co-occurring disorders;*

(d) *continued care coordination and management with the client's medical and psychiatric care providers;*
(e) *community based overdose prevention programs;*
(f) *employment resource; and*
(g) *community and social supports, including family support services.*

ABH Recommendation
Include in this list: "(h) Documentation of the client's agreement or of client's refusal to participate in said services."

3. **105 CMR 164.309 Involuntary Termination from an Opioid Treatment Program**
Currently Reads As:

(A) Emergency Terminations: the licensee may terminate a client immediately prior to a hearing and without provision for medically supervised withdrawal, under the conditions listed below:

(1) when the program director reasonably determines that the client's continuance in the program presents an immediate and substantial threat of physical harm to other clients, program personnel or property; or
(2) where the program's Medical Director reasonably determines that continued treatment of a client presents a serious documented medical risk; and
(3) the licensee immediately notifies the client of the decision and the reasons for the decision to immediately terminate the client;
(4) the licensee schedules a hearing, to be held on the next business day, on the decision to terminate and provides notice of the hearing to the client as described in 105 CMR 164.309(B)(1)(a)1. and 3. and (C);
(5) the hearing is conducted in accordance with procedures specified in 105 CMR 164.309(D): Hearing Procedures providing that the decision required by 105 CMR 164.309(D)(7) shall be made within one business day;
(6) the client is notified of findings of the hearing within one business day of the hearing;
(7) the licensee provides referrals to ensure a continuum of care for the client, including continued counseling and other services, including risk reduction and outreach. Licensees are not required to provide medically supervised withdrawal services to clients who are discharged on an emergency, involuntary basis.

ABH Recommendation
Emergency discharges are not planned. When an event happens that is a serious documented medical risk or an immediate and substantial threat of physical harm to other clients, program personnel or property, then immediate action must be taken whatever time or day that such situations occur. When a treatment team arrives at the decision to discharge involuntarily, without benefit of a methadone withdrawal schedule, the time of day may not be conducive to providing *prompt written notice.*

Although program staff send out a notice of termination promptly, it is often impossible for that client to receive it in time to respond back to the program about a time they can be available for a *next business day* hearing. This is not due to staff being irresponsible but rather that it may not reach the patient in time, so providers also always call the client to document what is being mailed to them.

ABH respectfully requests that the following regulatory language be inserted: "In the event that written notice cannot be sent or received in time to meet the timelines in the regulations 164.309 (3) through (6), the Program must document that it was sent out immediately after a decision to discharge was made and that the patient was informed of the reasons and their right to a next business day hearing. In addition that the patient was scheduled the hearing within the time frame of the regulations and that the patient was promptly notified of all decisions by phone as well as in writing."

4. **105 CMR 164.309 (D)(6) Involuntary Termination from an Opioid Treatment Program**

Currently Reads As:

(D) Hearing Procedures: The licensee shall ensure that hearings are conducted in accordance with the following procedures:

(6) The licensee shall make an audio recording of the hearing. The client may also make an audio recording of the hearing at the client's expense;

ABH Recommendation

ABH requests that DPH/BSAS eliminate 164.309(D)(6). Tape recording all the provider appeals hearings is a burden on providers and is not required by SAHMSA regulation. A tape recording of appeals hearings is not necessary, as all the required written documentation needed is submitted by providers to BSAS and maintained in the client record, and the client submits their material with their appeal.

MassHealth Psychiatric Day Treatment
130 CMR 417.000

The MassHealth PDT Regulations specify that PDT providers utilize the *Framingham Scale* to measure their clients' level of functioning. The Framingham Scale is an outdated instrument no longer required by MassHealth as it does not provide any clinical value. ABH requests that MassHealth delete all references to *Functional Level, Functional Level Review, Level of Functioning Scale and Framingham Scale* throughout 130 CMR 417.000, and Sub-Chapter 5, *Transmittal Letter PDT-13 dated 10/01/90, Section 524 - Level of Functioning Scale,* as follows.

1. **130 CMR 417.402 Definitions**

Currently Reads As:

- *Functional Level — the degree to which an individual can function independently in the community. Progressive levels of impaired functioning are evaluated using a Division-approved outcome measure (which includes criteria set forth in 130 CMR 417.411).*

ABH Recommendation

Delete definition of *Functional Level* and replace it with a definition for "Treatment Response - The degree to which an individual demonstrates progress toward goal achievement as evaluated by using a MassHealth approved instrument."

Currently Reads As:

- *Vocational Rehabilitative Services — services that provide vocational assessments, job training, career counseling, and job placement.*

ABH Recommendation
Expand definition of *Vocational Rehabilitation Services* to clarify the difference from *Pre-Vocational Activities*. For example, include job placement activities, job coaching, and temporary employment, and identify the CMS federal exclusions for Medicaid reimbursement.

- **Add Definition for *Enhanced Psychiatric Day Treatment***, as follows:

"Enhanced Psychiatric Day Treatment Programs are specialized programs designed to incorporate peer-led support and recovery services based upon the principles of psychiatric rehabilitation and recovery from addiction(s)." This enhanced model was developed by PDT providers in collaboration with the Massachusetts Behavioral Health Partnership. It is based on the philosophy that clients are entitled to services which promote their ability to live successfully in the community and to access community resources. By adding peer-led support and recovery services to psychiatric day treatment programs, the programs can further emphasize guidance and support services, empowerment services, and wellness and recovery training.

2. **130 CMR 417.411 Functional Level Review**

Currently Reads As:
(B) The Division may decide to review a member's treatment if examination of the member's functional level review forms indicates that one or more of the following applies:

ABH Recommendation
Delete functional level review and replace it with a definition for "*Treatment Response Review*" – which would require that all PDT providers integrate the use of a MassHealth approved instrument for measuring an individual client's progress toward goal achievement.

3. **130 CMR 417.421 Staffing Requirements**

Currently Reads As:
(A) Minimum Staffing Requirements.
(1) A psychiatric day treatment program with fewer than 28 participants must be staffed at a minimum by a treatment team of three qualified professionals. At least two of the treatment team members must be employed full time by the program. The third team member may be two part-time employees or one full-time employee.
(2) Programs with 28 participants or more must have one additional full-time professional for every eight additional participants.
(B) Composition of the Treatment Team.
(1) Each member of a treatment team must represent a different discipline from the other members of the same treatment team.
(2) At least two full-time staff members of the same treatment team must be drawn from the following disciplines: psychiatry, psychology and/or counseling psychology, social work, psychiatric nursing, licensed mental health counseling, occupational therapy, or rehabilitation counseling.
(3) The remaining members of the same treatment team may separately represent any disciplines listed in 130 CMR 417.421(B)(2) or expressive therapy or allied health.

(4) The composition of the treatment team must be appropriate to the needs of the participants and, where possible, include participant representation.

(C) Additional Staff. The program must ensure an overall staff-to-participant ratio of one to six by hiring additional professional or paraprofessional staff from any of the disciplines listed in 130 CMR 417.421(B)(2) and (3).

ABH Recommendations

ABH respectfully requests that MassHealth PDT Manual 130 CMR 417.421 (B) (above) mirror 105 CMR 140.540 DPH Clinic Licensure Regulations (below), as all PDT programs must be licensed by DPH Clinic Licensure Regulations per MassHealth regulations at 130 CMR 417.404.

DPH Clinic Licensure Regulations 105 CMR 140.530: Staffing reads as follows:

(B) Multi-disciplinary Staff.

(1) A multi-disciplinary staff must be available as appropriate for the clients' needs.

(2) A multi-disciplinary staff must be comprised of mental health professionals who meet the requirements set forth under 105 CMR 140.530(C). The staff may also include other related mental health professionals necessary for the provision of intake, evaluation, diagnostic and treatment services.

NOTE: The MassHealth Mental Health Center Manual at 130 CMR 429.432 had already been amended some years ago to mirror 105 CMR 140.540 DPH Clinic Licensure Regulations regarding multi-disciplinary teams.

ABH also recommends that 130 CMR 417.421 Staffing Requirements (A) (1) be revised by deleting *"with fewer than 28 participants"*. PDT programs should have at minimum three qualified professionals on staff even if the number of participants is less than 28 on any given day.

Finally, section (C) currently reads, *Additional Staff. The program must ensure an overall staff-to-participant ratio of one to six by hiring additional professional or paraprofessional staff from any of the disciplines listed in 130 CMR 417.421(B)(2) and (3).* ABH requests that this ratio be changed from *one to six* to *one to eight*, which is a ratio that produces sufficient additional staff to operate the PDT programs.

4. 130 CMR 417.437 Recordkeeping Requirements

Currently Reads As:

(A) A psychiatric day treatment program must maintain on its premises the original records for each member for a period of at least six years following the date of service.

ABH Recommendation

Maintaining client records on site for six years presents a challenge for most PDT programs as they often have limited space for the storage of paper records. ABH requests that this regulation mirror the DPH Medical Record requirements at 105 CMR 140.302 which allows for other means of storage and reads as follows:

105 CMR 140.302
(C) Retention of Medical Records.
(1) In accordance with M.G.L. c. 111, § 70 each clinic shall maintain records of the diagnosis and treatment of patients under its care for a minimum of ***20 years*** *after the discharge or the final treatment of the patient to whom the record relates. Medical records may be handwritten, printed, typed or in electronic digital format, or converted to electronic digital format or an alternative archival method. Handwritten, printed or typed medical records that have been converted to electronic digital format or an alternative archival format may be destroyed before the expiration of the 20 year retention period. The manner of destruction must ensure the confidentiality of patient information. For purposes of section 105 CMR 140.302, medical records in electronic digital format shall have the same force and effect as the original records from which they were made.*

5. **130 CMR 417.422 (A) (2) Organization Structure**

Currently Reads As:
(A) Program Director.
(1) A psychiatric day treatment program must designate a full-time professional as overall administrator and clinical director to be responsible for the program and charged with day-today responsibility over it.
(2) If the psychiatric day treatment program has more than 22 participants but less than 28, the program director must not also provide over 10 hours a week of direct service.

ABH Recommendation
ABH requests that (A)(2) be eliminated. PDT Program Directors perform many roles and wear many hats, and despite the number of participants in the program will deliver direct care service as needed based on staff attendance at any given time.

6. **130 CMR 417.435 (B): Case Management** and **130 CMR 417.437 (E) Record Keeping Requirements**

Currently Reads As:
417.435 (B) The case coordinator must review the member's treatment goals and level of functioning weekly and, during staff meetings, inform the staff of any significant changes in the member's medical, mental, or emotional status. The entire staff must review the member's overall progress every 60-calendar days and, with the participation of the member, alter or revise the treatment plan as necessary.

And, 417.437 (E) Record Keeping Requirements
Currently Reads As:
(11) a schedule of review dates to occur no less than once a month to reassess the member's progress in accomplishing goals and increasing the member's functional level

ABH Recommendation
These are conflicting requirements about the frequency of reviews in the MassHealth PDT Manual. ABH recommends that both these statements be changed to state that reviews be conducted *every 60 days*. PDT providers already conduct weekly reviews and write weekly

progress notes; they also use very quantifiable treatment plans. To also require a comprehensive review every month is excessive.

7. **130 CMR 417.435 Case Management**

Currently Reads As:
(B) The case coordinator must review the member's treatment goals and level of functioning weekly and, during staff meetings, inform the staff of any significant changes in the member's medical, mental, or emotional status. The entire staff must review the member's overall progress every 60-calendar days and, with the participation of the member, alter or revise the treatment plan as necessary.

ABH Recommendation
Delete "*level of functioning*" and insert in its place, "*overall response to treatment.*"

8. **130 CMR 417.437 Recordkeeping Requirements**

Currently Reads As:
(E) The member's record must include at least the following information:
(6) a comprehensive statement of the member's physical, psychosocial, social, economic, educational, and vocational assets and disabilities, stated in terms of the functional capacities of the member and summarized in a rating of the member's functional level;
(11) a schedule of review dates to occur no less than once a month to reassess the member's progress in accomplishing goals and increasing the member's functional level;

ABH Recommendation
Delete the words "functional level" from (E)(6) and (11) and insert it its place "treatment response."

9. **PDT Provider Manual Billing Instructions**

ABH Recommendation
Also, delete *Section 524 Level of Functioning Scale* language from Sub-Chapter 5, Transmittal Letter PDT-13 dated 10/01/90.

MassHealth Substance Abuse Treatment
130 CMR 418.000

1. **References to DPH Licensure of Substance Abuse Treatment Program Regulations, 105 CMR 164**

In 2008, the DPH/Bureau of Substance Abuse Services rescinded the following DPH regulations and replaced them with *105 CMR 164 Licensure of Substance Abuse Treatment Programs.*

The list of rescinded regulations includes:

- 105 CMR 160.000: Acute Care Inpatient Substance Abuse Detoxification Treatment Services

- 105 CMR161.000: Short Term Inpatient Treatment Centers
- 105 CMR162.000: Licensure of Substance Abuse Outpatient Services
- 105 CMR 165.000: Halfway Houses for Alcoholics
- 105 CMR166.000: Approval of Residential Alcohol Treatment Programs for Operating under the Influence Offenders
- 105 CMR 167.00: Methodology for Setting Fees for Driver Alcohol Education Programs and Treatment Programs Serving First Time Operating Under the Influence Offenders
- 105 CMR 750: Licensing and Approval of Drug Treatment Programs

ABH Recommendation
All references to the rescinded DPH regulations must be removed from the MassHealth Regulations and replaced with appropriate references to 105 CMR 164 *Licensure of Substance Abuse Treatment Programs*.

2. 105 CMR 418.406: Allowable Number of Take-homes for Methadone

Currently Reads As:
130 CMR 418.406: Service Limitations
(A) Methadone Treatment Programs.
(1) Payment for administering or dispensing methadone is limited to one dose per recipient per day. Payment for dispensing a take-home supply is limited to a maximum six days' supply.

ABH Recommendation
Amend this regulation so as to mirror the DPH Regulations at 105 CMR 164.304 Additional Service Requirements for Opioid Maintenance (C) (3) (f), which reads as follows:

(3) The licensee shall adhere to the following limits in providing take-home doses:
(f) Following completion of 18 months of treatment, ***the licensee may provide up to 13 take-home doses every two weeks.***

MassHealth Mental Health Center
130 CMR 429.000

1. Reporting Requirements

429.406: In-State Providers: Reporting Requirements

(A) All mental health centers must complete an annual report on forms furnished by the MassHealth agency and file them with the MassHealth agency within 90 days after the close of the MassHealth agency's fiscal year. The report must include the current staffing pattern, indicate any revisions or changes in written policies and procedures, describe the role of the psychiatrist, and provide any other information that the MassHealth agency may request.

ABH Recommendation
Delete this section. The information changes regularly due to staff turnover and there are numerous policy changes that are not relevant to operate a mental health clinic. Information

requested is time consuming and difficult to compile due to numerous staffing changes. Unsure if this is a federal requirement.

2. Staff Authorized in Mental Health Centers

429.424: Qualifications of Professional Staff Authorized to Render Billable Mental Health Center Services by Core Discipline

ABH Recommendation

Add Licensed Mental Health Counselor as qualified staff authorized to supervise pre licensed mental health counselors. Also add Licensed Alcohol and Drug Counselors (LADCs) as qualified staff to operate in a Mental Health Clinic. These provider types regularly operate in Mental Health Centers across the Commonwealth and are needed to preserve access to services for MassHealth members.

3. **Recordkeeping Requirements**

429.436: Recordkeeping Requirements (C)(14)

(14) a written record of quarterly reviews by the primary therapist, which relate to the short- and long-range goals;

ABH Recommendation

Change the timeframe required for the written record of quarterly reviews by the primary therapist, to "**as necessary but at least once a year**". This mirrors the current requirement for Mental Health Centers under 105 CMR 140.540 (D). Therapists are required to complete extensive documentation during care and develop and follow treatment and diagnostic plans.