

Massachusetts Department of Public Health

Monica Bharel, M.D., Commissioner

and Members of the Public Health Council

Submitted via: Reg.Testimony@state.ma.us

October 24, 2016

RE: Proposed changes to 105 CMR 140.000 Licensure of Clinics

Thank you for the opportunity to provide comments on the above-referenced regulation, which clearly is intended to bring clinic licensure into alignment with the many changes taking place in the health care system. Although the regulations do reflect these in part, particularly with the section related to mobile units, we are disappointed that two provisions which the League and its members have discussed with the Department over the years have not been included, and urge you to consider doing so.

Section 140.560. Over the years, one of the major requests that the League and its members have made to the Department has been to restore a *Community Health Center Outreach Program* provision which, prior to a regulatory revision sometime in the mid-1980’s, mirrored the *Mental Health Outreach Program* provision which remains in the regulation. Conversations with the former Commissioner and his staff, and more recently with Departmental staff led us to belief that this provision was likely to be included when the major upgrade was made.

There are two reasons why including it makes sense:

First, health centers that wish to provide primary care services to serve people in homeless shelters have been told that these sites must be licensed, and in many cases the sites do not meet clinic license requirements. Providing these services without licensure is not only in violation of the regulation, but also creates problems related to reimbursement and insurance coverage. As services are extended to care for more elderly patients, not having this provision will prevent serving them in congregate housing situations as well.

Second, primary care and behavioral health integration is a two-way street. Under the definition, a *Mental Health Outreach Program* is one which “provides services … in community health centers or hospital licensed health centers…” During the past four years, we have had two instances where behavioral health agencies were more than willing to include primary care providers from nearby community health centers at their facilities and were not able to do so because there was no provision in the licensing regulations to allow this to happen. These agencies instead hired their own primary care providers and by doing so lost the opportunity to make a major move toward the desired integration of their patients’ care. It is likely that a number of other relationships never even got started because the parties involved saw the lack of a regulation as a barrier. Maximizing ways in which primary care providers employed by community health centers can be included in the mental health and substance use disorder care for patients from their own community is a major goal of the system innovation activities which are currently taking place. We therefore strongly urge the Department to include a reciprocal Community Health Center Outreach Program section in the regulation.

140.103 (C): Several years ago, the League and our members worked with the former Commissioner and the staff of the Division of Health Care Quality (DHCQ) to identify ways in which the licensure process could be expedited. One of the major points of delay was caused because local Public Safely and Fire authorities do not issue certificates until a clinic is actually ready to open. However, in order to be actually ready to open, the clinic would have already met all DPH licensure requirements, including inspection, and the delay between DPH inspection, local inspections, providing notice to DPH, and getting the license could be several weeks. The Department agreed on a process in which a “provisional” license could be issued, to become effective when the clinic notified DHCQ of the successful completion of the local approvals. We anticipated that it would be included at the time when the Regulation was revised, and urge you to include it in the interests of efficiency.

140.099: We appreciate that the Waiver provision has been retained, but would like to request that it be extended to include expedition of approvals by DHCQ. As part of the same effort mentioned above, it was agreed upon to expedite project review by conducting a desk review of architectural plans for “routine” projects including but not limited to very small projects and renovations, but it is not clear whether this is still being done. As of this week, we have heard from two health centers of significant processing delay related to one center “bringing an exam room back into use,” and another about a possible delay of several months for expansions to their current facility. Most of our members have waiting lists for care and although workforce shortage is the major cause of these, delay in physical plant expansion is another. Including provisions in the Regulation which would explicitly allow for desk reviews and expedited approval of small projects would increase the efficiency of the Department and go a long way toward increasing the ability of the health centers to provide care to thousands of additional patients.

The League and the health centers truly appreciate the many years of successful collaboration with the Department and hope that these recommendations indicate ways in which this relationship can be strengthened. If you would like further information, please don’t hesitate to contact me.

Very truly yours,

Patricia Edraos

Health Resources/Policy Director