CHILDREN'S MENTAL HEALTH CAMPAIGN

MSPCC - BCH - HCFA - HLA - PPAL - MAMH

October 24, 2022

Executive Office of Health & Human Services
c/o D. Briggs
100 Hancock Street, 6th Floor
Quincy, MA 02171
masshealthpublicnotice@mass.gov

RE: Comments on 130 CMR 448.000: Community Behavioral Health Center Services

To Whom it May Concern:

On behalf of the Children's Mental Health Campaign (CMHC), thank you for the opportunity to comment on the proposed regulation 130 CMR 448.000: Community Behavioral Health Center Services. The CMHC is led by an Executive Committee of six organizations: the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care For All, Health Law Advocates, and the Massachusetts Association for Mental Health (MAMH). THe CMHC network includes over 200 organizations across Massachusetts.

We appreciate the leadership of the Executive Office of Health and Human Services and MassHealth in developing a system of community behavioral health centers for the Commonwealth and for establishing these high standards for centers' participation in MassHealth. Please find below comments on the proposed regulation 130 CMR 448.000 and do not hesitate to contact us with any questions or to discuss our comments further.

Thank you,

Mary McGeown
Executive Director, MSPCC
On behalf of the Children's Mental Health Campaign (CMHC)

THE CHILDREN'S MENTAL HEALTH CAMPAIGN is a large statewide network that advocates for policy, systems, and practice solutions and shared responsibility among government and institutions to ensure that all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way.

The CMHC Executive Committee consists of six highly reputable partner organizations: The Massachusetts Society for the Prevention of Cruelty to Children, Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care for All, Health Law Advocates, and the Massachusetts Association for Mental Health. The CMHC network includes more than 200 organizations across Massachusetts.

448.402: Definitions

The CMHC suggests the following modifications to several definitions in the proposed regulations. We also suggest that MassHealth align the terms used in the final regulations adopted for Mental Health Centers (130 CMR 429.000) with these proposed regulations (130 CMR 448.000: Community Behavioral Health Center Services) and future regulatory revisions to help ensure consistency across programs and provider types.

Adverse Incident – There also may be adverse incidents related to the actions of an individual who isn't technically a staff member, but who is present within an entity or a subcontractor of an entity. "Staff member" is not defined.

Behavioral Health Disorder – This definition should be changed to "Behavioral Health Condition" and the term "condition" should be used in place of the term "disorder" throughout in both the mental health and substance use contexts. The word "disorders" is stigmatizing. If individuals have physical health conditions, like diabetes or psoriasis, they aren't considered disorders. Parallel language should be used in the behavioral health context. In addition, the recently enacted Chapter 177 adds the new statutory section 81 to M.G.L. c. 118E, which requires MassHealth and its associated health plans and contractors to cover all services to diagnose and treat all behavioral health conditions listed in both the DSM and the International Classification of Diseases, or ICD. Therefore the CMHC recommends this definition of behavioral health conditions also incorporates by reference all behavioral health conditions listed in the DSM, as well as the ICD..

Case Consultation – The word "scheduled" should be deleted as it is too limiting. For instance, given Community-Based Behavioral Health Centers' (CBHCs') requirements to offer same day access to intake and brief assessment for non crisis services during business hours, urgent appointments within 48 hours for comprehensive diagnostic assessment, and urgent outpatient crisis counseling , providers will need more flexibility for case consultation beyond "scheduled" meetings only. Please also consider text consultations, as well as adding language for people who are deaf or hard of hearing. In addition, the potential limitation on preparation of reports on a patient's progress in treatment "(other than for legal purposes)" should be removed because some persons who are both justice-system involved and in active treatment for substance use conditions may require this type of information or these types of medical records in order to comply with court requirements.

Certified Peer Specialist – The definition of Peer Recovery Coach includes individuals with "lived experience with addiction and/or co-occurring mental health disorders." We suggest changing the definition of Certified Peer Specialist to include "lived experience with mental health conditions, lived experience with substance use conditions, and/or lived experience with co-occuring mental health and substance use conditions." We also suggest changing "disorder" to "condition."

Crisis Intervention – Crisis intervention should be more broadly defined than "an urgent evaluation." The service should include crisis assessment, intervention, and stabilization services. Further, the definition states that the intervention includes assessment of risk, but fails to identify the nature of risk. Perhaps the assessment should evaluate "risk of danger" rather than be an open ended evaluation of "risk."

Diagnostic Evaluation Services – We suggest that the evaluation might also examine intellectual and spiritual assets. The CMHC urges MassHealth to avoid the terms "assets" and "disabilities" in a way that seems to place them in opposition. Drawing from the Child and Adolescent Needs and Strengths (CANS) parlance, the CMHC suggests replacing "assets and disabilities" with "needs and strengths."

Direct and Continuous Supervision – Consider replacing "continuous" with "continual" since the proposed definition describes supervision that occurs at certain intervals. Intervals should be, as the term "continual" suggests, occurring at regular intervals.

Home Visits – A place where an individual resides or sleeps might not be their residence. We ask that MassHealth clarify whether home visits are available to individuals who are unhoused or who have housing instability.

Medication Visit – We suggest adding language to clarify that visits may include those for the purpose of monitoring medication side effects and medication withdrawal.

Mental Health Disorder - The word "disorder" is stigmatizing. If individuals have physical health conditions, like diabetes or psoriasis, they aren't considered disorders. Parallel language should be used for mental health. Please change to "Mental Health Conditions." In addition, the recently enacted statute M.G.L. c. 118E, §81 requires MassHealth and its associated health plans and contractors to cover all services to diagnose and treat all behavioral health conditions listed in both the DSM and the International Classification of Diseases, or ICD. Therefore the CMHC recommends this definition of mental health conditions also incorporates by reference all mental health conditions listed in the DSM, as well as the ICD.

Pharmacotherapy – We suggest amending the definition to read: providing "counseling regarding or" therapeutic treatment with pharmaceutical drugs "or therapeutic treatment for pharmaceutical drug tapering or withdrawal."

Quality Management Program – We suggest adding the following clause to the end of this definition: ", as well as potential forms of discrimination such as on the basis of race, ethnicity, language, religion, national origin, disability, sexual orientation, gender identification, or gender preference identity."

Recovery Support Navigator – Consider adding "and evidence-informed" after "evidence-based." Please also clarify the overall goal of the Navigator, that is to promote wellness and recovery.

Release of Information – Please add "or authorized representative" after "patient."

Substance Use Disorder – Please see comment above under "Mental Health Disorder."

Supervised Clinical Experience – Please see comment above about use of the term "continuous" as opposed to "continual"regarding the proposed definition for "Direct and Continuous Supervision."

Telehealth – We recognize that MassHealth is using the definition of Telehealth established in Chapter 260 of the Acts of 2020. The CMHC requests that the definition here be aligned with any further clarifications made in the final Division of Insurance regulations, which have not been released as of the date of this submission.

Urgent Behavioral Health Needs – In addition to "emerging intent of self-injury," please add

"self-destructive behavior." This accounts for behavior less severe than self-injury.

Youth Community Crisis Stabilization (YCCS)– We suggest moving the phrase "to individuals up to and including 18 years of age" earlier in the definition so that it isn't tied to the preceding clause. The CMHC also recommends adding the sentence, "Services also include the capacity to provide induction onto and bridging for medication for the treatment of opioid use disorders (MOUD) and withdrawal management for opioid use disorders (OUD) as clinically indicated." This is congruent with language for Adult CCS.

Youth Mobile Crisis Intervention (YMCI) - The CMHC recommends that MassHealth collaborate with the Group Insurance Commission (GIC) and the Division of Insurance (DOI) on the implementation of the new "Emergency Services Programs" benefits established under Chapter 177 of the Acts of 2022 (Sections 27, 49, 51, 55, 58, and 61). Implementation should be done in a manner that encourages the same naming conventions and definitions for services whenever possible. This practice will reduce provider and consumer confusion, increase transparency, and help ensure that individuals can access - and receive coverage for - these behavioral health crisis services.

Last, it might be helpful to have an entry for the term "treatment," as well as review the use of the term throughout the document. A definition might explain whether the term has a consistent meaning throughout or whether treatment is understood differently depending on the service being provided. Currently, the term is elaborated upon in a number of definitions, but it requires careful reading to find and understand its meaning. For example, the definition of Youth CCS describes services that are included for Youth CCS under the umbrella of "treatment." Other definitions refer to treatment, behavioral health disorder treatment (see CBHC definition), psychotherapeutic treatment, mental health treatment (see IOP), mental health and/or substance use disorder treatment, therapeutic treatment, etc. It is difficult to know which of these terms are synonymous, which are formal descriptions of a service, and which are discrete. It is also difficult to know, when the term "treatment" is used without modifiers, what services are encompassed in that term (for example, in the list of Youth CCS services). As one example, it is unclear when substance use condition treatment is included in that term in various contexts in which it is used.

<u>448.404: Provider Eligibility and 448.405 Provider Enrollment</u>

We recommend that MassHealth eliminate the requirement that a CBHC must be "enrolled as a Medicare Provider…." due to federal and state parity law obligations.

Under federal parity law, MassHealth must ensure that the nonquantitative limitations (NQTLs) applied to CBHCs are no more restrictive than the NQTLs applied to *all other* medical/surgical benefits in the same classification group.[1] It seems most likely that MassHealth should determine these CBHC benefits to be outpatient services for purposes of assessing parity, because the vast majority of these services are provided on an outpatient basis.[2] MassHealth does not require doctors, nurses, or highly comparable community health centers to enroll in Medicare in order to join the MassHealth provider network.[3] See 130 CMR 450; 130 CMR 433.401 to 473, 130

[1] See 42 CFR 457.496(d)(4i) and 42 CFR 440.395(b)(4) regarding NQLTs.
[2] Only the Adult Community Crisis Stabilization (Adult CCS) and Youth Community Crisis Stabilization (YCCS) could be considered to be inpatient services. However federal parity law allows a health plan to assign intermediate level benefits – such as residential treatment, skilled nursing, or rehab hospital treatment, which all include 24-hour care, to be classified as inpatient or outpatient services, so long as the plan does so in a consistent manner for both medical and behavioral health benefits. See 81 FR 18396, Medicaid Parity rule, March 30, 2016; 42 CFR 457.496(d)(2)(ii) and 42 CFR 440.395(b)(2)(ii).
[3] However, a subset of laboratory services and radiology services performed at a community health center must be performed by Medicare-certified individuals in order to be eligible for reimbursement. See 130 CMR 405.432(C) and 130 CMR 405.442(B).

CMR 414, 130 CMR 405, which include no broad requirement of Medicare enrollment. Therefore, because this proposed requirement that a CBHC must enroll in Medicare could be a restriction on behavioral health providers that is more restrictive than the standards for all other outpatient medical/surgical providers, this limitation would likely be a NQTL violation of existing federal parity law.[4]

In the event that MassHealth assigned CBHCs to the "inpatient" benefit classification group, MassHealth would need to show that this limit is based on standards or factors that are no more restrictive of the agency's "inpatient" medical/surgical benefits.[5]

Under the newly enacted state parity law requirements in Section 44 of Chapter 177, MassHealth would also need to show that this limitation is not a NQTL that applies only to behavioral health benefits.

Similarly, the requirement that a "separate . . . application for enrollment as a community behavioral health center must be submitted for each clinic location" may be a more burdensome administrative process for network admission, as compared to MassHealth's more streamlined process for either an on-campus and off-campus "Hospital satellite clinic" to join MassHealth's network, under 130 CMR 410.402 (citing 42 CFR 413.65, which at 413.65(b)3) (allows satellite clinics of hospitals to participate through an attestation of common licensure, financial integration, common ownership and supervision, etc.) Therefore we recommend that MassHealth carefully review this requirement for admission to the network for compliance with both newly enacted state parity law requirements under Section 44 of Chapter 177, and federal parity law requirements.[6]

448.406: Required Notifications and Reports

(A)(2) Annual Report (Staffing and Personnel Reports) – We recommend that MassHealth also require data on the number of patients served and FTEs for those services to understand if staffing levels are sufficient. In addition to a statement describing the "current language capacities," the CMHC also recommends that each CBHC be required to submit race and ethnicity data on all clinical and non-clinical staff. This data will help the Commonwealth understand the diversity - or lack thereof - of the CBHC workforce and help support planning and strategy for future workforce development initiatives.

(C) Adverse Incident Reports – In addition to Adverse Incident Reports, agencies should be required to report on complaints filed with the Department of Public Health Division of Health Care Facility Licensure and Certification.

448.408: Maximum Allowable Fees

As delineated in the performance specifications as part of the procurement process, CBHCs should have the capacity to serve members in their preferred language, including offering interpreter and translation services for those with Limited English Proficiency and who are deaf or hard of hearing. CBHC reimbursement should take language capacity into account, especially for those centers located in regions of the state with higher need.

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[4] See 42 CFR 440.395(b)(4)(ii)(C), noting that "Standards for provider admission to participate in a network" can be a non-quantitative treatment limitation that violates the parity requirements for Alternative Benefit Plans, i.e. MassHealth Standard, MassHealth CarePlus); and 42 CFR 457.496(d)(4)(ii)(D), noting same for CHIP plans, i.e. MassHealth Family Assistance.

[5] MassHealth does require acute care hospitals (which are classified as "inpatient" benefits) to enroll in Medicare under 130 CMR 410.402, 410.404(A), but the agency does not require rehabilitation hospitals to enroll in Medicare. See 130 CMR 430.

[6] See note 3.

448.409: Non Reimbursable Services

(A)(3) Educational services – MassHealth does not define educational services; certain psychoeducation and related services can be an important component of the treatment and recovery process.

(A)(5) Life enrichment services – It is not clear what is meant by "functioning persons." Likewise, workshops and education courses provide benefits beyond "ego enhancing."

448.410: Site Inspections

(B) Corrective Action Plan – In addition to MassHealth reviewing a corrective action plan, we suggest that MassHealth conduct a follow up inspection to ensure that the corrective action plan has been implemented by adding language reflecting this to the end of clause.

448.411: Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

We commend MassHealth for reiterating the federal - and corresponding state - Medicaid EPSDT coverage requirements. We suggest adding to this section a reference to coverage for services within the Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) Services protocol, which is a state protection similar to EPSDT for children and adolescents receiving MassHealth Family Assistance, the state's Children's Health Insurance (CHIP) program (130 CMR 450.150).

448.412: Scope of Services

(A) Required Services – We suggest that consideration be given as to which of the services listed, in addition to crisis services, could be offered by telehealth and by text message, when clinically appropriate and agreed upon between the CBHC and the member(s) being served.

(A)(2) and (A)(3) Diagnostic Evaluation Services, Treatment Planning Services – The treatment plan should be offered to the member and, if applicable, the member's authorized representative, for review and acceptance. Services provided should be those which have been accepted. If a plan is not accepted by the member, it should be revised to reflect the member's wishes. Treatment plans also should be updated upon request of the member and/or the member's authorized representative. Members should be offered the assistance and/or participation of a certified peer worker in the treatment planning process.

(A)(5) Pharmacotherapy Services – Pharmacotherapy services also should include counseling about thoughts and concerns on medication use, as well as medication withdrawal services. The allowance of a one-time administration of a medication in an emergency also should state that such administration must be in accordance with *Rogers v. DMH*, 390 Mass. 489 (1983). In (g)4, we suggest an addition so that the text reads: "performing medication adjustment and/or advising regarding a medication withdrawal plan."

(A)(7) Mobile Crisis Intervention Services - The CMHC requests clarification from MassHealth as to why Youth Mobile Crisis Intervention services do not also include the "capacity to screen for substance intoxication or withdrawal, and to provide access to medications for opioid use disorder for induction and urgent psychopharmacology."

For Youth Mobile Crisis Intervention, we suggest the following:

- In (A)(7)(b)(4), clarifying what the phrase "as clinically indicated" means in the requirement for

follow up care, as it could be read to suggest that follow up care might not be appropriate in some circumstances, but provides no explanation.

- In (A)(7)(b)(6), allowing care coordination with existing social services providers in addition to medical and behavioral health providers, if central to resolving the crisis.
- In (A)(7)(b)(6), clarifying what the phrase "as clinically indicated" means in the requirement for follow up care with existing medical and behavioral health providers, as it seems it would always be important to communicate with those providers about the usage of crisis services

(A)(8) Community Crisis Stabilization

(a) Youth Community Crisis Stabilization (YCCS) - The CMHC suggests changing (2) to read "crisis stabilization, comprehensive assessment, and treatment." We also suggest adding new services, including: (8) inductions for FDA-approved medications for opioid use disorder and other substance use conditions; (9) family partners, peer supports, and other recovery-oriented services; (10) daily re-evaluation and assessment of readiness for discharge; (11) psychoeducation, including information about recovery, wellness, and crisis self-management; (12) a discharge plan that includes referrals to appropriate levels of care, facilitation of connections and/or admission to such levels of care; and follow-up instructions; and (13) care coordination with existing medical and behavioral health providers, as clinically indicated.

(A)(10) Medical Services – The regulations should make clear in what circumstances a member has a right to refuse toxicology screenings and what services may or may not be available should a member refuse.

(A)(11) Certified Peer Specialist Services – The regulation suggests that MassHealth will only reimburse certified peer specialists for the listed functions. We are concerned that this list may prevent a peer specialist from performing other important functions. We suggest aligning reimbursement to functions supported by SAMHSA.[7].

<u>448.413 – Staff Composition Requirements</u>

(B)(3) Multidisciplinary Staff – MassHealth proposes that "each center must employ a multidisciplinary staff that includes at least two of the following behavioral health professionals…" The types of professionals listed have significantly different training, competencies and roles. For example, an independent social worker and a certified peer specialist provide different services and are not interchangeable. We request clarification as to the intent of this section of the regulations to ensure that all centers have a level of multidisciplinary staff necessary to meet the required competencies and services pursuant to 448.412, and whether additional staff that can serve children and families, such as family partners and therapeutic mentors should be included as options.

(C) Minimum Requirements for Center Administrative and Clinical Management Staff – We request that MassHealth elaborate upon what constitutes "training" and "experience" within the requirement for "previous training or experience in personnel, fiscal and data management." Specifying the requisite training and experience needed for each position, while enabling CBHCs to conduct post-hiring training, would establish a baseline of core competencies and allow centers the flexibility to conduct training for any lacking credentials. Further, in (C)(2)(a), we suggest this addition: "and will be employed <u>by the center</u> on a full-time basis."

(D) Mobile Crisis Intervention Services Staff – In (D)(2)(c), we suggest that the multidisciplinary staff for the

[7] See SAMHSA, Peer Support Workers for Those in Recovery: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

YMCI mirror the staffing requirement for AMCI regarding a certified peer specialist and recovery support navigator or peer recovery coach, or that such individuals be available for consultation as necessary.

(E) Community Crisis Stabilization Services Staff – In (E)(4), we suggest that all staff be trained in the use of Naloxone, not simply one staff member per shift.

(F) Youth Community Crisis Stabilization– In (F)(4) , we have the same comment regarding access to certified peer support as above re (D)(2)(c). We also support the inclusion of staff members trained in CPR and the use of Naloxone to mirror the Adult Community Crisis Stabilization staffing requirements.

448.414 – Supervision, Training, and Other Staff Requirements

(A)(2)(b) Staff Supervision Frequency/Unlicensed or Not Independently Licensed Staff – We recommend further clarification regarding the meaning of "direct and continuous supervision." Does this entail simultaneous, ongoing supervision? And, if so, the regulation should reinforce that when telehealth supervision is used, it must still be simultaneous supervision.

(A)(4) The regulation should clarify that supervision notes are entered in the member's record and members may have access to supervision documentation.

(B) Staff Training – The CMHC recommends changing the language in (6) to read "training on overdose prevention and response, including administration of opioid antagonists." We also recommend staff training on implicit bias on race, ethnicity, age, primary language, gender, sexual orientation and disability. There should also be training on suicide prevention, as well as training on patient rights, including the rights of minors. The CMHC also recommends training staff that work with youth on age-specific issues, such as behavioral health care and support during infancy and early childhood, childhood, adolescent years, and young adulthood.

448.418 Utilization Review Plan

(A) The utilization review committee should verify that treatment plans were prepared with the participation of the member and/or authorized representative and were consistent with the member's wishes.

(F) After the utilization review, any determination regarding continuation, modification, or termination of treatment should be made in consultation with and participation by the treating provider and the member. MassHealth should also clarify in regulations whether it is only the primary therapist that will be informed of the utilization review panel's decision or other members of the person's care team. The regulations should also reference member appeal rights regarding discontinuation or modification of services.

448.419 – Recordkeeping Requirements

(B) Member Records, (3) Records should include a log of who has access to the record and with whom it was shared. (3)(p) should be amended to indicate that the member should have the opportunity to choose to sign the treatment plan. (3)(q) should be amended to include any documentation or correspondence that the member wishes to be added to the record. (4) Brief History for Emergency and Walk-In Visits – It is not clear whether this means that all the requirements of (3) still need to be followed. It would seem that many of the requirements in (3) would still apply. If (4) is intended solely to modify the requirement in

(3)(g), requiring record of "the relevant medical, psychosocial, educational and vocational history" we recommend that MassHealth directly modify that clause to read: "the relevant medical, psychosocial, education and vocational history, except in cases of emergency and walk-in visits, for which a brief history is acceptable when the treatment plan does not call for extended care;"

(D) Availability of Records – The records also should be made available to the member and if appropriate, to the member's authorized representative, upon request.

448.420 – Written Policies and Procedures

Each center also should have formal patient complaint, patient rights, suicide prevention and language access processes and policies.

448.422 – Outreach

We recommend changing the language from "home visits" to "visits where the individual is residing" in the event that the member is unhoused or has housing instability.

448.423 – Service Limitations

(D) Case Consultation – We request clarification as to whether personal meetings may also be conducted by text. We also request that MassHealthadd language for communication services for people with Limited English Proficiency or who are deaf or hard of hearing. Finally, schools should be included in case consultation for children and adolescents.

(G) Psychological Testing – We recommend adding language that the individual and, if applicable, their authorized representative, consent to testing.

Comments concerning federal and state law parity compliance

A number of sections in the proposed regulations are likely potential violations of federal and state parity law, because those sections impose restrictions or limitations on access to outpatient behavioral health services that are more restrictive than MassHealth's limitations on the comparison group of other outpatient medical and surgical services.[8] The sections that we recommend MassHealth review more fully for compliance with federal and state parity laws are:

448.409 Nonreimbursable Services (A) Nonmedical Services - This section includes more restrictive limitations on types of permissible services than, for instance, the "Medical Social Services" that are payable and actually required to be provided by Community Health Centers. See 130 CMR 405.408(E).

448.410: Site Inspections - MassHealth regulations do not require community health centers, doctors or nurses (i.e. comparable outpatient medical-surgical services providers) to submit to unannounced site inspections the MassHealth as a funder. The shadow of this kind of looming regulatory oversight by a funder could easily communicate a discriminatory message to the staff and providers at these facilities, in contrast to MassHealth treatment of comparable medical facilities. This requirement could also violate state and federal parity laws.

[8] We assume that these CBHC benefits are primarily if not entirely to be treated as outpatient behavioral health benefits. MassHealth is required to assign each benefit to a "benefit classification group" (as defined by federal law) in order to then assess if the agency's management of access to those benefits complies with federal parity law.

Additionally, the RFP[9] issued by MBHP for these CBHC services does not include a similar 'surprise inspection' requirement for those CBHCS that MBHP is actually helping to fund the start-up costs for, so requiring this for MassHealth's fee-for-service network is inconsistent. Instead, MassHealth should work with the Department of Public Health to establish whether any such additional regulatory scrutiny in this form by MassHealth is necessary for purposes of quality control. If MassHealth concludes that additional regulatory oversight of this type is necessary due to the novel nature of these facilities, one reasonable approach would be to require an initial site-visit, comparable to MassHealth's certification process for community health centers under 130 CMR 405.405(A), (D), et. seq., which allow an initial site visit, and subsequent site visits "upon reasonable notice and at any reasonable time during the hours of operation…." If not, it would be reasonable to time-limit this 'surprise inspection' requirement as an interim requirement during the CBHC's first 12 or 24 months of operation.

448.423: Service Limitations (B) Multiple Visits on a Same Date of Service;.
This subsection of the proposed regulation could be a violation of state and federal parity laws. Such limitations are not imposed by MassHealth upon community health centers under 130 CMR 405 or upon physician practices under 130 CMR 433, two types of out-patient providers that are good comparators for purposes of federal parity law.

448.423: Service Limitations (C) Multiple Therapies.
Similarly, this subsection of the proposed regulation could be a violation of state and federal parity laws for the same reason – such a limitation is not imposed by MassHealth upon community health centers under 130 CMR 405 or upon physician practices under 130 CMR 433, two types of out-patient providers that are good comparators for purposes of federal parity law. Many medical/surgical conditions require multiple treatment approaches simultaneously, and the choice of how and whether to combine such treatments is left to the treating providers exercising their judgment according to generally accepted standards of care, and upon the individual needs of the patient. A regulatory limitation like subsection 448.423(C) could unnecessarily interfere with the treating provider's exercise of judgment.

448.423: Service Limitations (G) Psychological Testing
This subsection of the proposed regulation could be a violation of state and federal parity laws. Specifically, newly enacted Section 44 of Chapter 177 includes new statutory section 81 of M.G.L. c. 118E, which requires MassHealth all services "for the diagnosis and medically necessary treatment of any behavioral health disorder described in the" DSM or the ICD. To the extent that any psychological testing is necessary for the diagnosis of a behavioral health condition, limitations under this subsection G of regulation 448.423 (or under the cross-referenced regulation 101 CMR 411.000: Psychologist Services) other than under the standard of "medical necessity" would violate this newly-enacted state parity law.

In addition, to the extent that this regulation 448.423(G) limits reimbursement for psychological testing, in terms of access to the services, or in terms of the level or amount of reimbursement to a CBHC, this regulation (and the cross-referenced regulation 101 CMR 411.000) could be a violation of federal parity law. MassHealth must ensure that the reimbursement rates for behavioral health services are in parity with reimbursement for medical/surgical services, by using the same set of factors, standards or processes to determine those reimbursement rates.

448.414: Supervision, Training, and Other Staff Requirements
Several provider organizations noted that the proposed supervision requirements exceed current

[9] MBHP Procurement for Community Behavioral Health Center Programs, Request for Proposals, Feb. 1, 2022, available at https://www.masspartnership.com/pdf/CBHC-RFP-2-1-22FIN.pdf.

professional licensure requirements, and they would be exceptionally burdensome to the CBHC which are struggling to attract and keep qualified staff. Similarly, these supervision requirements are significantly more restrictive than the rules for community health centers under 130 CMR 405, which actually seem to expand access to medical services by extending coverage for various services delivered by a center staff person “under the supervision of a physician” or other medical provider in some cases. Thus section 448.414 could likely also violate federal and state federal parity law.

Similarly, the imposition of arbitrary services, such as regular updates of treatment plans or re-assessments of prescribing choices, could also be violations of state and federal parity law if MassHealth does not apply these requirements (or the underlying medical management standards or factors that support the need for these requirements) uniformly and consistently to all outpatient benefits.