Report From Agency

ADMINISTRATIVE RULES
REPORT TO LEGISLATURE
CLEARINGHOUSE RULE 06-080

By the Department of Health Services ch. HFS 35 and ss. HFS 105.22 and 107.13, relating to outpatient mental health clinics, and affecting small businesses.

Basis and Purpose of Proposed Rule

The Department's authority to revise or repeal ss. HFS 61.91 to 61.98 and create ch. HFS 35, and amend ss. HFS 105.22 and 107.13 is as follows:

- Section 49.45 (10), Stats., requires the Department to promulgate rules that are consistent with its duties in administering medical assistance.

- Section 51.03 (4) (f), (g) and (h) and (5), Stats., authorizes the Department to promote access to appropriate mental health and alcohol and other drug abuse services; consumer decision making to enable persons with mental illness and substance use dependency to be more self sufficient; use of individualized treatment plans, developed with consumers and families of consumers who are children, and advocates chosen by consumers, that promote treatment and recovery, establish meaningful and measurable goals for the consumer, that are based on assessment of the consumer's strength and abilities, needs and preferences, and that are modified as necessary.

- Section 51.04, Stats., authorizes the Department to certify treatment facilities for the receipt of funds for services provided as a benefit to a medical assistance recipient under s. 49.46 (2) (b) 6. f., Stats., a community aids funding recipient under s. 51.423 (2), Stats., or as mandated coverage under s. 632.89 (2), Stats.

- Section 51.42 (7) (a), Stats., requires the Department to review and certify county departments of community programs and community mental health programs to assure that the county department and programs are in compliance with the purpose and intent of s. 51.42 Stats., to enable and encourage counties to develop a comprehensive range of services offering continuity of care; to utilize and expand existing governmental, voluntary and private community resources for provision of services to prevent or ameliorate mental disabilities, including mental illness, developmental disabilities, and alcoholism and drug abuse; to provide for the integration of administration of those services and facilities organized under s. 51.42, Stats., through a county department of community programs; and to authorize state consultative services, review and establishment of standards and grants-in aids for such program of services and facilities.

- Section 51.42 (7) (b), Stats., requires the Department to promulgate rules which govern the administrative structure deemed necessary to administer community mental health services; prescribe standards for qualifications of personnel; prescribe standards for quality of professional services; govern eligibility of patients to the end that no person is denied service on the basis of age, race, color, creed, location or inability to pay; to establish medication procedures to be used in the delivery of mental health services; establish criteria for the level of scrutiny of evaluation of community mental health programs, and prescribe requirements for certification of community mental health programs.

The current rules for outpatient mental health clinics are under ss. HFS 61.91 to 61.98. These regulations address procedures for certification; required personnel; service requirements; and denial, involuntary termination or suspension of certification for outpatient mental health clinics; clinical supervision, clinical collaboration, and clinical consultation; written authorization of psychotherapy by a physician; initial assessments of clients and development of treatment plans; progress notes; discharge summaries; and record keeping. In addition to these requirements, the rules require clinics to ensure continuity of care for persons with mental disorders or alcohol and drug abuse problems by rendering or arranging for the provision of specified services, including but not limited to, residential facility placement; aftercare for continuing treatment in the community to help the patient maintain and improve adjustment following a period of treatment in a facility; and emergency care. Sections HFS 61.91 to 61.98 have not been comprehensively reviewed and rewritten since May 1981.

Section HFS 105.22 provides the requirements for medical assistance certification of psychotherapy providers, staffing of outpatient facilities, and medical assistance reimbursement for outpatient psychotherapy services. Section HFS 107.13 (2) details the medical assistance requirements for covered services for outpatient psychotherapy services, prior authorization and other limits and procedures, and non-covered services under the medical assistance program.

Section HFS 105.22, was last revised in 1991 and s. HFS 107.13 (2) has not been comprehensively reviewed and rewritten since March 1986.

In meeting the above listed statutory objectives, the Department proposes to revise or repeal ss. HFS 61.91 to 61.98 and create ch. HFS 35 to do all the following:

- Eliminate burdensome provisions that do not help to lead to the desired outcomes for persons who receive outpatient mental health services treatment.

- Codify, in rule, the statewide variances that have been issued by the Department to outpatient mental health providers.

- Increase flexibility for clinic operations including allowing certified clinics to alternatively meet the standards of one of several national accrediting bodies when applying for renewal certification; permit clinics to provide clinical collaboration as part of the clinic's quality improvement process; allowing mental health professionals to provide the recommendation for psychotherapy for consumers who are not medical assistance recipients; and allow the provision of psychotherapy services in the clinic, a branch office, or alternate location.

- Establish certification and enforcement processes that are similar in both organization and content to the certification and enforcement processes set out in rules for other certified community mental health programs.

- Clarify the minimum staff requirements for a clinic; and the role of professional staff of a clinic, including for persons who prescribe medication within a clinic.

- Clarify record keeping requirements for psychotherapy notes.

- Establish training requirements for clinic staff.

- Add or expand language on admission, assessment, consent for treatment, treatment planning and medication administration, standards for electronic records, and consumer rights.

- Incorporate the provisions under s. 50.065, Stats., and chs. HFS 12 and 13 that require caregiver background checks on clinic staff and reporting of clinic staff misconduct.

- Increase consumers' participation in treatment planning resulting in treatment that is recovery-based and consumer-directed.

The Department proposes to revise ss. HFS 105.22 and 107.13 (2), to ensure that the language in these rules is consistent with the language in the proposed ch. HFS 35 and that these rules reflect current practices and needs. Covered services are not proposed to change.

Responses to Legislative Council Rules Clearinghouse Recommendations

The Department accepted the comments made by the Legislative Council Rules Clearinghouse and modified the proposed rule where suggested.

Final Regulatory Flexibility Analysis

The proposed rules will affect a substantial number of small businesses, but will not have a significant economic impact on those businesses. The Department believes that any increase in operating costs or decreases in revenues that may be caused by the proposed rules are expected to be less than the 2005 Consumer Price Index of 3.4% which is the CPI prior to the year the small business impact analysis was conducted.

Changes to the Analysis or Fiscal Estimate

Analysis

- Based on public comment, language relating to certification of exceptional clinics was removed from the analysis because the department removed provisions relating to certification of exceptional clinics from the proposed rule.
- Based on public comment, the number of minimum staffing hours licensed treatment professionals and mental health practitioners must be available to provide outpatient mental health services to consumers was changed in the analysis because the requirements were revised in the rule. Instead of requiring licensed treatment professionals or mental health practitioner to each be available for 37.5 hours per week, the proposed rule now allows the hours available to be 75 hours combined and 37.5 hours combined respectively.
- Based on comments from the Legislative Council Rules Clearinghouse, the department made technical changes to the analysis.

Fiscal Estimate

No changes were made to the fiscal estimate.

Public Hearing Summary

The Department held 3 public hearings in July and August 2006, one each in Madison, Wausau and Waukesha. Notice of the public hearings was published in the Wisconsin Administrative Register and on the Wisconsin Administrative Rules Website. Comments on the proposed rules were received by the Department until November 2006. In addition to public hearings, the Department held 6 public listening sessions in October and November 2005 in Madison, Wausau, Waukesha and Wauwatosa. Notice of these listening sessions was placed in the Capital Times, the Milwaukee Journal Sentinel, and on the Wisconsin Administrative Rules Website.

List of Public Hearing Attendees and Commenters

The following is a complete list of the persons who attended the public hearing or submitted comments on the proposed rule, the position taken by the commenter and whether or not the individual provided written or oral comments.

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
1.	Cindy Lindgren 2917 International La Suite 300 Madison, WI 53704	No position taken	Observe
2.	Dale Decker Moontree Psychotherapy Center, LLC 401 Wisconsin Ave Madison, WI 53704	Oppose	Oral
3.	Jann Liliegren, MSSW, LCSW PO Box 132 Dodgeville, WI 53533	Oppose	Oral
4.	Janet K Devore DHFS/SRO, Rm 639 1 W Wilson St Madison, WI 53702-7850	No position taken	Observe
5.	Hal Rosenberg, LCSW 7818 Big Sky Dr. Madison, WI 53719	Oppose	Oral & Written
6.	Lynn Gutkneckt 6001 Research Park Madison, WI 53719	Oppose	Written
7.	Tracy Lewis, LCSW Suite 204 1050 Regent St Madison, WI 53715	Oppose	Written
8.	Linda Denis Oakley 600 Highland Ave Madison, WI 53792-2455	Oppose	Oral & Written
9.	Cara Hoffert 921 Chapel Hill Rd Madison, WI 53711	Oppose	Oral & Written
10.	Sara Bowen 126 Franklin St Madison, WI 53703	No position taken	Observe
11.	Rick Ruecking DHFS	No position taken	Observe
12.	Jim McGliome, PhD, LCSW 2700 Marshall Ct., Ste. 1 Madison, WI 53705	Oppose	Oral & Written
13.	Richard Hennessy Madison Mental Health Services 2700 Marshall Court, Ste 1 Madison, WI 53705	Oppose	Oral & Written
14.	Alisa Kelly-Martina 619 River St., Ste F Belleville, WI 53508	No position taken	Observe & Written
15.	Ruth Ann Berkholtz 5534 Medical Circle Madison, WI 53719	Oppose	Observe & Written
16.	M. Keane 6417 Odana Rd.	Oppose	Observe & Written

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
	Madison, WI 53719		
17.	Lawrence Nash, MD 700 Rayovac Dr., Ste 220 Madison, WI 53711	Oppose	Observe
18.	Bonnie Conway Family Therapy Ctr. Of Madison 700 Rayovac Dr. #220 Madison, WI 53711	Oppose	Written
19.	Anne Beal, LCSW 700 Rayovac Dr. Ste 220 Madison, WI 53711	Oppose	Observe
20.	Rick Russo, LCMSW Madison Psychotherapy Assoc 1400 E Washington Ave, Rm. 187 Madison, WI 53703	Oppose	Written
21.	Mark Hale DHFS/DQA 2917 International Lane, Rm. 300 Madison, WI	No position taken	Observe
22.	Dianne Greenley Disability Rights WI 131 W Wilson Madison, WI	Support	Written
23.	Carol Faynik, MA, LCSW 700 Rayovac Dr. Ste 220 Madison, WI 53711	No position taken	Oral & Written
24.	Sharon Boesl Sauk County DHS 505 Broadway Baraboo, WI 53913	No position taken	Observe
25.	Mark Herstand c/o NASW WI 16 N. Carroll St, Ste. 220 Madison, WI 53717	Oppose	Oral & Written
26.	Susan W. Brooks Madison Psychiatric Associates 5534 Medical Circle Madison, WI 53719	Oppose	Written
27.	Harvey R. Dym, MSSW, LCSW 4813 Tocora Lane Madison, WI 52711	Oppose	Written
28.	Jack Kaufman, DSW, LCSW, LMFT 313 Price Place, Ste 10 Madison, WI 53705-3250	Oppose	Written
29.	Jeannett Welty Journey Counseling, LLC 6417 Odana Rd Madison, WI 53719	Oppose	Written
30.	Terry Bucleger 6417 Odana Rd Madison, WI 53719	Oppose	Written

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
31.	Erica Serlin, PHD Family Therapy Ctr. Of Madison 700 Rayovac Dr. Madison, WI	Oppose	Oral & Written
32.	Chris Wolf 1 W Wilson St Madison, WI	No position taken	Observe
33.	Margaret Parsons, PHD 607 N. Sales Merrill, WI 54452	No position taken	Oral
34.	Jim Hahn 1225 Langlade Rd Antigo, WI	Support	Written
35.	Gina Bryan 1310 Hanover Ct. Waunakee, WI 53597	No position taken	Oral & Written
36.	Vern Weeks 8893 250th St. Cadott, WI 54727	Oppose	Oral & Written
37.	Charles J. Herman 471 Kelvington Dr. Sun Prairie, WI 53590	No position taken	Observe
38.	Eugene J. Herman 730 8th Ave Antigo, WI 544409	No position taken	Observe
39.	Gary Yeast PO Box 615 Wausau, WI 54402-0615	Support	Oral & Written
40.	M. Lee Shipway, CSSW 7055 24th Ave, Ste 402 Wausau, WI 54401	Oppose	Oral
41.	Dan Buso Catholic Charities/Diocese of LaCrosse 1317 College Ave Stevens Point, WI 54481	No position taken	Observe
42.	Andy Benede 807 S. 20th St Wausau, WI	No position taken	Written
43.	Jeanne P. Maher Wraparound Milwaukee 9201 W. Watertown Plk Rd Wauwatosa, WI 53226	No position taken	Observe
44.	Janet Friedman Wraparound Milwaukee 9201 Watertown Plank Rd Milwuakee, WI 53223	No position taken	Observe
45.	Eluria Villonreae 9201 Watertown Plank Rd Milwaukee, WI	No position taken	Observe
46.	Jan Schier 459 Prospect Ave. #9	Oppose	Written

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
	Pewaukee, WI 53702		
47.	Robb Simcock Prohealth Care Behavioral Medicine Ctr 721 American Ave., Ste 501 Waukasha, WI 53186	Oppose	Observe
48.	Kelly A. Farber 6204 W. Lloyd St Wauwatosa, WI 53213	No position taken	Observe
49.	Laura Lamont 3266 N. 80th St Milwaukee, WI 53222	No position taken	Observe
50.	Robert W. Marrs 2719 N. 67th St. Milwaukee, WI 53210	No position taken	Written
51.	Thomas Galten 420 Seventh St Racine, WI 53403	No position taken	Observe
52.	Jennifer Beyer 707 W Moreland Blvd, Ste 5 Waukesha, WI 53188	No position taken	Observe
53.	Lisa Keating MSW, LCSW 707 Moreland Blvd, #5 Waukesha, WI 53188	Support	Observe
54.	Romona Powers Women & Families Psychotherapy Resources 111 Sunset Dr. Pewaukee, WI 53072	No position taken	Oral
55.	Sheryl A. Van Haren 7365 W Bluemound Rd #206 Milwaukee, WI 53213	Oppose	Written
56.	Ronald Pupp 1212 S. 70th St Milwaukee, WI 53214	No position taken	Oral
57.	Mike Boticke, PHD 1220 Mound Ave. Ste 301 Racine, WI 53406	No position taken	Observe
58.	Dismas Becker 1533 N/ 23rd St Milwaukee, WI 53205	Support	Oral
59.	Michael Lappen 121 W Main St Port Washington, WI 53704	No position taken	Observe
60.	Richard Powers Women & Families 707 W. Moreland Blvd Waukesha, WI 53188	No position taken	Observe
61.	Joan Kotis PHD 121 W. Main St. Port Washington, WI 53704	No position taken	Observe
62.	Jerrold B. Rousseau MSSW, LCSW	Oppose	Oral & Written

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
	6270 N. Port Washington Rd Ste 201 Glendale, WI 532098		
63.	David L Hubbard, PHD New Life Resources, Inc. 20700 Watertown Rd Waukesha, WI 53186	No position taken	Observe
64.	Dan Green, PHD New Life Resources, Inc. 20700 Watertown Rd Waukesha, WI 53186	No position taken	Observe
65.	Linda Pellmann N64W34863 Rd J Oconomowoc, WI 53066	No position taken	Observe
66.	Eve Lipchik, MSW, LMFT, LCSW 1524 N. Farwell Ave Milwaukee, WI 53202	Oppose	Oral
67.	Myles Tonnacliff 1011 N. 8th St Sheboygan, WI	No position taken	Observe
68.	Gina Singletery 6737 W Washington St. #2210 West Allis WI 53214	No position taken	Observe
69.	Shanna Sullivan 1545 S. Layton Blvd Milwaukee, WI 53215	No position taken	Observe
70.	Chyra Trosst, LCSW LaCausa, Inc 1545 S Layton Blvd Milwaukee, WI 53215	No position taken	Observe
71.	Patrick Patterson Milwaukee County Behavioral Health Div/ Sail 9201 Watertown Plank Rd Wauwatosa, WI 53226	No position taken	Observe
72.	Daniel Barkarsh, PhD 6300 Univ Ave Ste 225 Middleton, WI 53562	Oppose	Written
73.	Don Norman, PhD WI Assoc for Marriage and Family Therapy PO Box 44578 Madison, WI 53744	Support	Written
74.	Carolyn Moynihan, President Clinical Social Work Federation-WI	Oppose	Written
75.	Patricia Miles, LCSW Midwest Ctr for Psychotherapy and Sex Therapy 6300 University Ave. Ste 225 Middleton, WI 53562`	Oppose	Written
76.	Irene Cunningham irenec@core.com	Oppose	Written
77.	Margaret Tungseth Tungseth Psychotherapy Clinic, LLC 6233 Durand Ave Ste F	Oppose	Written

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
	Racine, WI 53406		
78.	Charles J. Trimberger 83surfy@earthlink.net	Oppose	Written
79.	Alice Mirk BMH&SA Services	No position taken	Written
80.	Jennifer L. Burelbach 505 King St, Ste 25 La Crosse, WI 54601	Oppose	Written
81.	Gayle Ellis gmellis@mac.com	Oppose	Written
82.	Donna Ulteig. LCSW, DCSW, BCD 2727 Marshall Court Madison, WI 53705	Oppose	Written
83.	Nan Upright-Sexton Adoption Resources 6682 W Greenfield Ave # 310 Milwaukee, WI	Oppose	Written
84.	Bonnie L Connolly, MALPC 33130-73rd Street Burlington, WI 53105	Oppose	Written
85.	Karen Pleshe kpleshe79@yahoo.com	Oppose	Written
86.	Jane James janerj@inxpress.net	Oppose	Written
87.	Francis Czarnecki fczarnicki@sbcglobal.net	Oppose	Written
88.	Eve Lipchik, MSW, LCSW, LMFT icfeve@sbcglobal.net	Support with comment	Written
89.	Jean Lemanske All-Area Counseling Services 719 West Main Street Wautoma, WI 54982 lemanskijean@yahoo.com	Oppose	Written
90.	Linda Hall lhall@wafca.org	Support	Written
91.	Patricia B. Richgels, LICSW, LMFT, CADCIII Human Development Associates 2920 East Avenue South La Crosse, WI 54601	Oppose	Written
92.	Paula Larson, LCSW 1039 W. Mason St. Green Bay, WI 54303	Oppose	Written
93.	John F Macek macekj@uww.edu	Oppose	Written
94.	Jean Lemanski, MSE, LPC, CADC Executive Director All-Area Counseling Services 719-West Main Street Wautoma, WI 54982	Oppose with comment	Written
95.	Deborah Lau Schingen 230 W. Wells St. #309	No position taken	Written

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
	Milwaukee, WI 53203		
96.	Alex Walkowiak, LCSW Joy of Life Center centpos@ticon.net	Oppose	Written
97.	Sandra Regan, PhD WPA Advocacy Cabinet Director WI Psychological Association 126 S. Franklin St. Madison, WI 53703	Oppose	Written
98.	Thomas O'Connor LCSW Madison Psychiatric Associates, Inc. 5534 Medical Circle Madison, WI 53719-1298	Oppose	Written
99.	Shari Cohn, MSSW, LCSW, SC Midwest Ctr. For Psychotherapy and Sex Therapy 6300 University Ave. Ste #225 Middleton, WI 53526	Oppose	Written
100.	Barbara Meyer meyerdaav@aol.com	Oppose	Written
101.	Kay Adams-Fleig LICSW W3909 Swamp Rd West Salem, WI 54669 skadamsfleig@centurytel.net	Oppose	Written
102.	Robert Beck, LCSW rmbec@hotmail.com	No position taken	Written
103.	Thomas Roberts, LCSW, Director Innerchange Counseling 757 Sandlake Rd Onalaska, WI 54650	Support	Written
104.	Maria Stevens ascootie@yahoo.com	No position taken	Written
105.	Janyse L. Bice-Allen 425 S. Adams St., Ste 204 Green Bay, WI 54301-4117	Oppose	Written
106.	James LaJeunesse MS JLajeunesse.CFEL@century.net	Oppose	Written
107.	Lynn Gutknecht MA migutknecht@wisc.edu	Oppose	Written
108.	Cindy Patterson-Rhorer MS-MTF, CICSW,CFT trhorer@earthlink.net	Oppose	Written
109.	Beth Wortzel LCSW bwortzel@chorus.net	Oppose	Written
110.	Gail H. Price, MSSW,LCSW,CADCIII 2614 Waunona Way Madison, WI 53713	Oppose	Written
111.	Jim Howell	Oppose	Oral
112.	DyAnn Buechler docdyann@aol.com	No position taken	Written
113.	George J. Kamps, MSW, ACSW, LCSW Chair Joint Bd of MFT, PC, & SW 1400 E Washington Ave.	No position taken	Written

Name and Address		Position Taken (Support or Opposed)	Action (Oral or Written)
	PO Box 8935 Madison, WI 53708-8935		
114.	Elizabeth Lindner, RN, PhD, APNP	No position taken	Written
115.	Darald Hanusa, PhD, LCSW Midwest Ctr for Human Services. Ste 10 Madison, WI 53705	Oppose	Written
116.	Meredith Sary, MA, LPC-TR, NCC msary@pathinc.org	Oppose	Written
117.	John A. Helf, LCSW	Oppose	Written
118.	Richard J Hennessey. LCSW Doctor's Park 2700 Marshall Court, Ste. 1 Madison, WI 53705	Oppose	Written
119.	Gina M Greatens, MS, LMFT, Fox View Behavioral Health 130 E. Walnut St., Ste 415 Green Bay, WI 54301	Oppose	Written
120.	Karen Littig, NCC Credence – Therapy Assoc. 1½ West Geneva St. Elkhorn, WI 53121	Oppose	Written
121.	Jim Salasek, Ph.D. Director, Behavioral Health Services St. Agnes Hospital 430 E. Division St. Fond du Lac, WI. 54936-0385	Oppose	Written
122.	Dr. Robert B. Shapiro Shapiro_d@sbcglobal.net	Oppose	Written
123.	Andrea E. Torres MA, LPC Harmonia: Madison Center for Psychotherapy Andtorres1@charter.net	Oppose	Written
124.	Arlene Langley alangley@nnex.net		
125.	Patty Faber, MSW pkf@tznet.com	Oppose	Written
126.	Kathleen Bahler Nemick MSSW, ACSW, CICSW Kathleen Bahler & Assoc 315 S. Jefferson St. Green Bay, WI 54301 bahnem@mindspring.com	Oppose	Written
127.	Cynthia J. Connolly MSW, LCSW 1636 Galax Drive Manitowoc, WI 54220	Oppose	Written
128.	Steven Miller Life-Span Family Services 13035 West Bluemound Road, Suite 100 Brookfield, WI 53005	Oppose	Written
129.	Molly Cisco Grassroots Empowerment Project PO Box 8683 Madison, WI 53708	Support	Written

Name and Address	Position Taken (Support or Opposed)	Action (Oral or Written)

Public Comments and Department Responses

The number(s) following each comment corresponds to the number assigned to the individual listed in the Public Hearing Attendees and Commenters section of this document.

Rule Provision	Public Comment	Department Response
1. General Comment	The Wisconsin Coalition of Marriage and Family Therapists, Professional Counselors, and Social Workers Inc. voted 8 to 0 to endorse the new administrative rules for outpatient clinics. The Wisconsin Coalition is comprised of the following professional and provider associations: Clinical Social Work Federation-Wisconsin; Wisconsin Association for Marriage and Family Therapy; Wisconsin Association of Behavioral Health Services; Wisconsin Counseling Association; and Wisconsin Mental Health Counseling Association. Note: The National Association of Social Workers, Wisconsin Chapter participates in meetings, but is not a voting member of the Coalition. The new rules resolve a majority of the problems in the current rules. 40	No response necessary.
2. General Comment	We welcome the increased flexibility provided in the rule. 92	No response necessary.
3. General Comment	Providing vendorship for master level practitioners would consolidate enforcement and eliminate the need for master's licensed practitioners to work in clinics to receive insurance payments. The rule duplicates the oversight of licensing boards and is a financial burden. Provisions of the rule are already in professional practice laws and rules. Rules of any kind from DHFS imply that mental health professionals need regulation by two agencies. Certify sole practitioners as a clinic or otherwise allow the master's level practitioners to function on their own. 2, 3, 5, 7, 9, 13, 15, 16, 17, 18, 20, 23, 25, 26, 27, 28, 31, 35, 37, 40, 57, 74, 76, 77, 78, 79, 82, 83, 84, 86, 88, 90, 94, 97, 102, 103, 107, 109, 111, 112, 115, 117, 118, 119, 129, 130	The subject of vendorship for master level practitioners is beyond the scope of the Department's legislated authority and mandate under s. 51.42 (7) (a) and (b), Stats., to ensure community mental health facilities' compliance with s. 51.42, Stats., and to promulgate rules that govern the administrative structure of outpatient mental health clinics, and prescribe requirements, including personnel standards, for certification. The proposed rules do not prevent a sole proprietor from owning or operating an outpatient mental health clinic. While some rule provisions may seem duplicative of the oversight provided by the applicable licensing boards, provisions in proposed ch. HFS 35 are geared toward the licensed program and entity, not the

Rule Provision	Public Comment	Department Response
		individual. Nevertheless, the Department has made revisions to the proposed rule in an effort to clarify the Department's intent and requirements.
4. General Comment	There is a clear distinction between private and public clinics and the rules should reflect that distinction. 9, 15	The Department believes that it would be infeasible, from a regulatory standpoint, to have separate requirements for public and private clinics because there are no clear distinctions in the populations served or in the source of funding or payments for services. Public and private clinics serve persons receiving MA or county funding, and those who have mental health issues that range from mild and intermittent to severe and persistent. All consumers, irrespective of their source of funding, diagnosis, or the clinic in which they receive services, should be accorded the same consumer protections.
5. General Comment	The rule treats physicians, psychologists, and master level practitioners differently. 2, 3	Without a specific reference as to how the rule treats the disciplines differently, it is difficult to respond to this comment except to say that the Department's expectations for assessment, treatment planning, documentation, and other requirements are the same for all disciplines that provide outpatient mental health services in outpatient mental health clinics.
6. General Comment	Do not allow unlicensed practitioners to practice as psychotherapists in the Department certified clinics. Permitting mental health practitioners to provide psychotherapy conflicts with the Department of Regulation and Licensing requirements for persons who provide psychotherapy to be licensed under chs. 455 or 457, Stats. 25, 37, 52, 75, 82, 99, 115, 118	§§ 457.02 (6) (a) and (b) permits persons granted through a process recognized by the department of health and family services, to practice psychotherapy. The definition for "mental health practitioners" under s. HFS 35.03 (10) has been revised to allow only individuals who meet that definition before January 1, 2014, to practice psychotherapy in outpatient mental health clinics. Persons who do not meet that requirement by January 1, 2014 must be licensed by the Department of Regulation and Licensing to practice psychotherapy in outpatient mental health clinics. In addition, s. HFS 35.127 has been revised to allow graduate students and persons with a graduate degree in specified disciplines to practice psychotherapy only under clinical supervision pursuant to MPSW 4, 12, 16, or Psy 2, as applicable. Clinics may require clinical supervision for mental health practitioners and recognized psychotherapy

Rule Provision	Public Comment	Department Response
		practitioners.
7. General Comment	Some commenters disagree with the Department's analysis that the benefits of the proposed rule outweigh foreseen costs. The rule increases administrative costs. The option to substitute clinical collaboration for supervision does not represent a substantial cost savings, if any at all. 2, 3, 5, 7, 9, 15, 17, 18, 23, 27, 31, 76, 83, 84, 88, 94, 102, 118	As stated in the fiscal analysis, the Department expects the proposed rule to benefit consumers by improving access, consumer protection, and quality of care and quality of life. According to the data from the survey of certified clinics conducted by the Wisconsin Association of Behavioral Health Services, the proposed rules would not increase costs for the majority of clinics. Clinics using clinical collaboration, which is currently allowed under waiver by the Department, realize a cost savings over the supervision requirement under the existing rules. Existing rules require supervision of clinic personnel by a psychiatrist or psychologist. The Department estimates that only about 150 of the 837 certified clinics do not already meet at least one of the proposed staffing requirements. The Department believes that these clinics will be able to meet the staffing requirement without increased costs because of the staffing options available, including the option to staff a clinic by agreement or employment. The Department has not received any evidenced-based data from clinics or others to refute its analysis of the rule's impact on small businesses.
8. General Comment	The statewide variances to the current rule are not included in the proposal. 25, 57, 64, 76, 87, 89	The concepts of the statewide variances relating to supervision and group therapy sessions are incorporated into the proposed rule. The Department believes that the proposed rule language simplifies and clarifies the requirements a clinic must meet. The Department, however, revised the language of the provisions relating to variances to clarify the Department's intentions, and to comply with rule writing requirements under ch. 227, Stats.
9. General Comment	The term "staff" is confusing throughout the rule because in some places, the term refers to an individual and in other places, the term refers to many or all persons in the clinic. 99	References to "staff" have been changed to "staff member" or "staff members" to provide clarity.
10. General Comment	The term "need" must be defined. 80	The Department does not believe a definition is necessary. The term "need" is intended by the Department to mean the commonly understood meaning of the word as evident from the context within which the term is used.
11. General Comment	The term "available" does not appear to be	Under s. HFS 35.03 (2), the term "available"

Rule Provision	Public Comment	Department Response
	used consistently. 99	is part of a phrase that is defined. Language in other rule provisions that included the term has been revised to remove the term.
12. General Comment	The term "consumer" should be replaced with the term "client" or "patient." 5, 99	The use of the term "consumer" is part of a national trend and is currently the accepted term in use by the federal Substance Abuse and Mental Health Administration and the National Institute of Mental Health. The Department has chosen to embrace the term as a way to help reduce the stigma related to persons receiving mental health services, and to promote the provision of mental health services as a participative process, in which the consumer has an active role in his or her treatment. A clinic is not required to use the term "consumer." A clinic may choose to use the term "consumer", client, patient, or a different term within their operation to refer to persons receiving outpatient mental health services from the clinic.
13. General Comment	The rule does not address the question of minors who have been charged as adults and court-ordered for assessment or treatment. 99	The commenter appears to want direction about a minor's legal status for consent, which may be affected in many different ways by a court order (e.g., under chs. 48 or 54, Stats. – guardianship; ch. 51 – involuntary commitment; ch. 971 – incompetent to stand trial or a commitment of a person found not guilty by reason of mental disease or mental defect; etc.). The issues involved with such court orders are complex and would be difficult to address within an administrative rule. In addition, such issues are beyond the scope of the proposed rules.
14. 35.03 (6)	The term "one of the behavioral sciences," needs to be defined to exclude behavioral ecology, anthropology etc. 99	Language in all sections that contained the phrase "one of the behavioral sciences" has been revised to replace the phrase with the following language "… psychology, counseling, marriage and family therapy, social work, nursing or a closely related field".
15. 35.03 (11)	The definition of "mental health practitioner" should include Marriage & Family Therapists, Professional Counselors, and Clinical Social Workers 97	The definition of mental health practitioner is renumbered s. HFS 35.03 (10) and revised as suggested by the comment.
16. 35.03 (12)	Delete the reference to an advance practice nurse practitioner and substitute "or an advanced practice nurse who is board certified in psychiatric and mental health nursing from the American Nurses Credentialing Center." This language change will help to ensure that the majority of advanced practice psychiatric nurses are not	Section 35.03 (12) was renumbered s. HFS 35.03 (11) and revised to remove advanced practice nurses from the definition of mental health professionals under s. HFS 35.03 (11). A definition of recognized psychotherapy practitioner" was added to the rule at s. HFS 35.03 (17r) "Recognized psychotherapy practitioner." This term means "an individual

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	excluded. The statement, "3,000 hours of supervised clinical experience including at least 1,000 hours of face-to-face contact with consumers," is redundant. It will not allow psychiatric advanced practice nurse prescribers to work as prescribers. 8, 36, 83	who may lawfully practice psychotherapy within the scope of a license, permit, registration or certificate granted by this state other than under ch. 455 or 457, Stats." The term will address all professional disciplines rather than just advance practice nurses. The definition of "mental health professional" at s. HFS 35.03 (11) was revised to mean "a licensed treatment professional, a mental health practitioner, a qualified treatment trainee, or a recognized psychotherapy practitioner." Under s. HFS 35.127, any mental health professional may practice psychotherapy. A separate definition exists under s. HFS 35.03 (16) for "prescriber". The definition includes advanced practice nurses acting in accordance with s. N8.06.
17. 35.03 (12)	The rule should only include private practice school psychologists. 99	Section 35.03 (12) was renumbered s. 35.03 (9g) and revised to include licensed private practice school psychologists.
18. 35.03 (12)	The inclusion of post-graduate degree individuals working on 3,000 hours is welcome. It increases the clinic's ability to hire and increase resources. 92	No response necessary. A definition of "qualified treatment trainee" was added at s. HFS 35.03 (17m) to provide greater clarity. "Qualified treatment trainee" means either of the following: (a) A graduate student who is enrolled in an accredited institution in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field. (b) A person with a graduate degree from an accredited institution and course work in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field who has not yet completed the applicable supervised practice requirements described under chs. MPSW 4, 12, or 16, or Psy 2 as applicable.
19. 35.03 (15)	The definition of "outpatient mental health services" is too comprehensive, many activities of a clinic do not involve diagnosis treatment planning, or treatment, should only include clinical services and specify other activities not subject to the same requirements as clinical services. 7, 37, 40, 99	Section HFS 35.03 (15) has been revised to mean "the services offered or provided to a consumer by a clinic, including intake; assessment; evaluation; diagnosis; treatment planning; psychotherapy; and medication management."
20. 35.03 (16)	The definition of "parent" may not be complete; consider a woman who has had a fertilized egg (not her own) implanted. The definition needs to be stated clearly whether or when foster parents and legal guardians	Section HFS 35.03 (16) was deleted and incorporated into the definition of "legal representative" at s. HFS 35.03 (9) (c). The definition of "parent" was revised to reference the definitions of "parent" in ss.

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	have any of the same rights and responsibilities as parents. 99	48.02 (8), (11) and (13), Stats. Any further definition of "parent" by the Department may be contrary to statute, and the Department's authority to promulgate rules. Under s. HFS 35.03 (10) (c), which is renumbered s. HFS 35.03 (9) (c), the Department defines the term "legal representative." The term is used where necessary in the rule to delineate when a person other than a parent has rights and responsibilities under the rule.
21. 35.03 (17)	The definition of prescriber refers to an advance practice nurse under ch. 441. This should be corrected by deleting "under ch. 441, Stats." and insert "prescriber under ch. 441.16, Stats." 8, 36	Section HFS 35.03 (17) has been renumbered HFS 35.03 (16) and revised to " …an advance practice nurse prescriber acting within the conditions and limitations set forth in s. N 8.06 which references s. 441.16 (3) (cm), Stats.
22. 35.03 (18)	Within this definition, there is a reference to "differential diagnostic examination." The term, "differential diagnostic examination," should be defined and the pertinent Department of Regulation and Licensing (DRL) references as to who is qualified to perform these should be noted. 99	Section HFS 35.03 (18) has been renumbered to HFS 35.03 (17) and revised to mean "any activity that falls within the definitions set forth at s. 457.01(8m) or 455.01(6), Stats." For the purposes of Medicaid reimbursement, the definition of psychotherapy in HFS 101.03 (145) still pertains.
23. 35.03 (19)	The inclusion of recovery concepts within the rule is strongly supported. 22, 131	No response necessary. The definition of "recovery" was renumbered to HFS 35.03 (18).
24. 35.03 (21)	Need to amend the definition of "substance abuse counselor" to include reference to either s. 457.02 (5m), Stats., or s. MPSW 1.09 to recognize the substance abuse counselor specialty. 115, 116	The Department revised the definition of "substance abuse counselor" to be the definition given under s. RL 160.02 (26).
25. 35.03 (22)	The definition of "substance abuse disorder" is both too specific and not specific enough, since it is limited to a focus on the listed areas. The more inclusive areas of behavioral and emotional functioning should be included. 99	The Department has revised the definition of "substance use disorder" to be the definition given under s. RL 160.02 (28).
26. 35.03 (23)	Face-to-face needs to identify what makes it clinical in nature. 99	The definition of "supervised clinical experience was eliminated from the rule because it was duplicative of the definition of clinical supervision. The definition of "clinical supervision," which was renumbered to HFS 35.03 (5) does not include the phrase "face-to-face supervision." This definition, in part, refers to "the supervised practice of psychotherapy as described under chs. MPSW 4, 12, or 16, or Psy 2, as applicable."
27. 35.03 (24)	The recognition of the importance of trauma within the rule is supported. 22, 131	No response necessary. The definition of "trauma" has been renumbered as HFS 35.03 (23).
28. 35.04	The rule potentially is unworkable in small	Section HFS 35.04 has been revised and

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	rural settings. Psychiatrists are rare in rural areas and are not likely willing to make such written agreements. Referral agreements are at odds with the needs of consumers who must follow their insurance company's requirements about who they see for care in order to be reimbursed. In addition, consumers want a choice of providers if they can have it. 2, 3, 5, 15, 18, 25, 37, 57, 58, 75, 76, 79, 80, 97, 100, 109, 117, 118	renumbered as HFS 35.123. Private and public clinics have reported difficulty in meeting current requirements of having a psychiatrist or psychologist to work in the clinic or to accept referrals from the clinic. To address these issues, the Department proposes two options for staffing under s. HFS 35.123 that do not require a psychiatrist or psychologist to provide psychotherapy, clinical supervision, or clinical collaboration. In the first of the minimum staffing options specified under s. HFS 35.123, two or more licensed treatment professionals are required to be available to provide services for at least 75 hours per week. In the second staffing option, one or more licensed treatment professionals must be available to provide services for at least 37.5 hours per week, as well as one or more mental health practitioners, who are not licensed, but who have completed the required supervised post-graduate experience must be available to provide services for at least 37.5 hours per week. Recognized psychotherapy practitioners may provide psychotherapy, but are not included in the minimum staff requirements. The proposed rule requires clinics to have a written referral agreement with an entity or individual if a clinic does not have a staff member who is a prescriber, and if the clinic does not have a staff member who has knowledge and skills to provide substance abuse assessments and services. The Department believes clinics should have these formal agreements in place to ensure continuity of clinical care to consumers. A prescriber, as defined under s. 35.03 (16) can be a physician, physician assistant, or an advanced practice nurse prescriber. The proposed rule does not require consumers be referred to a particular provider.
29. 35.04 (1) (d)	The Department should not require training and experience to work with children 13 years of age and younger. 15, 76, 99	The Department views s. HFS 35.04 (1) (d), which has been renumbered s. HFS 35.123 (3), as an important consumer protection because the needs of children and adolescents are significantly different from those of adults. A person working with children or adolescents should have the appropriate qualifications to treat the special needs of this group of consumers. This requirement is consistent with the conduct requirements for

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		licensed mental health professionals that prohibit the professional from performing or offering to perform services for which the credential holder is not qualified by education, training or experience.
30. 35.04 (2)	The rule should be amended to permit "a combination of professionals adding up to 40 hours per week." 91 Why is 37.5 hours specified? What about part time practices? Availability by phone or arranged backup should be plenty. 5, 9, 22, 25, 37, 40, 41, 43, 57, 64, 76, 79, 85, 93, 96, 99, 105, 108, 110, 114	Section HFS 35.04 was renumbered as HFS 35.123 and revised to indicate that the availability of mental health professionals and mental health practitioners *combined* be at least 75 hours per week. The revision clarifies the Department's intent to permit individual staff members to work part time while maintaining that the clinic operate on a full-time basis. Consumers are able to choose to see a psychotherapist who works part-time or full-time within a certified outpatient mental health clinic or in private practice. A clinic may indicate in its policies for emergency services, per s. HFS 35.165, that staff will be available by phone to help address a mental health emergency or crisis during hours when the clinic is closed. The Department believes that operation of a clinic full-time is an important consumer protection. If there are at least two staff members of the clinic are available to provide services at least 75 hours per week, then there is a reasonable likelihood that the consumer will have access to services when needed, that there is coverage for a staff member when on vacation or otherwise not available, etc. It is important to note that if a clinic presents information regarding its efforts to comply with the minimum staffing requirements, a clinic may request a waiver. If the Department believes that granting the waiver request will not adversely affect the health, safety or welfare of consumers, the Department may grant the waiver.
31. 35.04 (2) (c)	A psychologist or physician should not be required to provide services four hours per month; having them available would be more acceptable, or refer for service. 5, 85, 110	Section HFS 35.04 (2) (c) was renumbered as HFS 35.123 (2) (c) and revised to remove the reference to psychologist. The section now more accurately reflects that the Department's intent for this third option of minimum staffing is to have a psychiatrist, or advanced practice nurse prescriber, available as a second staff member of the clinic to meet

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		the medication needs of the consumers. If a clinic chooses not to have one of these prescribers as a staff member of the clinic, then the clinic is required to have a written arrangement with at least one prescriber to accept referrals from the clinic, and must meet one of the other options for minimum staffing of the clinic.
32. 35.04 (2) (c)	The proposed rule equates doctorate-level professionals with one level of master's level professionals. 99	Section HFS 35.04 (2) (c) was renumbered as HFS 35.123 (2) (c). Chapter 457, Stats, permit licensed marriage and family therapists, professional counselors, and credentialed social workers to practice psychotherapy. Section HFS 35.123 (2) (c) is an option for staffing, which has been revised to clarify that this option requires a person who can prescribe medications to consumers. Under s. HFS 35.04 (4) (a), a clinic that does not have a prescriber as a staff member must have a written referral agreement with an individual or entity to provide treatment to consumers to ensure continuity of clinical care, including prescribing medication. The reference to psychologist has been removed from s. HFS 35.123 (2) (c).
33. 35.04 (2) (e)	The reference to an "entity" should be deleted, as a written agreement with an entity may be a violation of confidentiality. 99	Section HFS 35.04 (2) (e) was renumbered as HFS 35.123 (4) (a) and (b). The requirement for written agreements is to ensure that consumers who do not have a current relationship with a prescriber or substance abuse counselor have access to a prescriber or substance abuse counselor, if the clinic does not have individuals on staff members who are qualified to perform these services and the consumer needs services from a prescriber or substance abuse counselor. A consumer has the right to choose to see a prescriber or substance abuse counselor that is not under a written agreement with the clinic. In addition, a consumer must provide consent to release confidential treatment information, in accordance with s. 51.30, Stats, HFS 92 and HIPAA requirements. The reference to "entity" permits a written agreement with a medical clinic or outpatient substance abuse clinic in addition to an

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		individual (i.e., a prescriber or substance abuse counselor). All medical and mental health professionals must comply with the applicable statutes and regulations related to confidentiality of treatment information.
34. 35.04 (4) (a)	There should be a provision to prevent professionals who may have voluntarily surrendered or had other disciplinary action taken against them. Delete the provision so that a person who has been suspended or revoked would not be allowed to work in any capacity in the clinic. 99 115	Section HFS 35.04 (4) (a) has been renumbered as s. HFS 35.123 (6) and prohibits individuals who have voluntarily surrendered a professional license from being employed in a clinic or under contract with a clinic as a "mental health professional" or a prescriber. Several sections in the rule prohibit an individual who has had a professional license revoked, suspended, or voluntarily surrendered from practicing psychotherapy in a clinic. Based on public comments, language was added in several sections to indicate that a person whose professional license is limited or restricted, may not be employed or contracted with to practice in areas prohibited by the limitation or restriction. The Department believes that a decision to not employ or contract with a person in any capacity whose licensure is suspended or revoked is a hiring decision that should be left to the discretion of the clinic subject to an action enumerated under s. HFS 35.03 (9m) committed by staff members.
35. 35.04 (4) (b)	This requirement regarding continued training necessary for licensure by the Department of Regulation and Licensing should be eliminated as it is micromanaging and duplicative with DRL. 99	The requirement has been removed from the proposed rule.
36. 35.05 (1) (c)	Define "accredited institution" as the Department of Regulation and Licensing does. Specify that the graduate student is completing clinical experience under the supervision of a licensed professional, as required by training. 99	This section has been eliminated and incorporated into a definition of "qualified treatment trainee" at HFS 35.03 (17m). The Department believes references to "accredited institution" is a commonly understood phrase, and, therefore, needs no definition. Language in the rule has been revised to require students and persons with graduate degrees, in the disciplines specified, provide psychotherapy only under clinical supervision as defined under s. HFS 35.03 (5).
37. 35.06	This rule should only apply if the consumer is actively involved in ongoing treatment. 99	The Department does not believe a revision is necessary. The rule only requires the clinic to report the death of a consumer as required

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		under s. 51.64 (2), Stats., which in pertinent part requires the clinic to report the death of a consumer to the Department within 24 hours if the death is related to suicide, physical restraint, or a psychotropic medication. If the consumer is discharged as that term is defined under s. HFS 35.03 (8) and a discharge summary has been completed under s. HFS 35.22, it can be logically assumed the clinic would not have an obligation under s. 51.64 (2), Stats. Due to the dynamic nature of the consumer/therapist relationship, it would be difficult to objectively define "actively involved" and "ongoing treatment".
38. 35.07	The rule should clarify where outpatient services are to be delivered (e.g., would another practice location of a physician/psychiatrist, psychologist, advanced practice nurse prescriber qualify?). 75	The proposed rule under s. HFS 35.07, require services to be provided at the clinic or a branch office, but allows services to be provided in alternate locations such as nursing homes, schools, medical clinics, the consumer's home, or other locations appropriate to support the consumer's recovery. The Department believes additional specificity would impede the flexibility the therapist may need in providing services to clients when needed.
39. 35.08 (1) (a) 3. and 4.	The rule should include Medicare certification of providers. 99	The rule was amended to include a reference to Medicare wherever there is reference to Medicaid. Section HFS 35.08 (1) a. 3. is renumbered s. HFS 35.03 (9m) (c).
40. 35.08 (1) (a) 4.	Add the phrase "or as permitted by standards of practice regarding the use of extenders" (e.g., a psychometrist). 99	Section HFS 35.08 (1) (a) 4. is renumbered as 35.03 (9m) (d) and was amended to delete "… except as permitted by Medicaid or Medicare rules or HFS 75." It was determined that even if Medicaid, Medicare or other payer requirements permit an extender or delegate to perform a service, it is illegal (fraudulent) for a person to sign a billing statement that he/she performed a service when in fact the service was performed by another person. It is acceptable for an extender or delegate to sign the billing statement with the supervising professional to countersign; reimbursement for such services is dependent on a payer's requirements rather than HFS 35 requirements.
41. 35.08 (2)	The rule should specify a minimum level of insurance required and clarify if clerical staff must be included. 99	The Department believes that the amount of insurance coverage required for a clinic should be left to the discretion of the clinic and its insurer. Suggesting minimum levels in rules could become outdated in a relatively

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		short time. The content of s. HFS 35.08 (2) was incorporated into HFS 35.08 (1).
42. 35.08 (3) (a) (intro.)	Delete the phrase "and or all." 99	The Department has revised s. HFS 35.08 (3) (a) (intro.) to remove the phrase "and or all" and replaced it with the word "any". During a compliance review for certification, or during a complaint investigation or death investigation, it may be necessary for Department staff to review information it determines is necessary to verify the clinic's compliance with the rule. Section HFS 35.08 (3) (a) (intro.) is renumbered s. 35.08 (2) (a) (intro.)
43. 35.08 (3) (a) 3.	Eliminate intrusive site visits to assure confidentiality and only investigate complaints. Consumers object to the violation of confidentiality by random review of charts. 17, 18, 27, 28, 74, 82, 86, 88, 101, 103, 109	HIPAA and s. 51.30, Stats., permit Department access to records without written consent. The biannual renewal certification surveys, death investigations, and complaint investigations, including the grievance process, are important consumer protections. In addition, these processes are important for accountability when public funds are expended.
44. 35.08 (3) (b)	Define "closed consumer records." 99	Section HFS 35.08 (3) (b) is renumbered 35.08 (2) (b) and has been revised to clarify that the reference is to records of consumers who have been discharged.
45. 35.08 (3) (c)	Add "and any applicable state and federal laws and regulations." 99	The rule language was amended to include the suggested phrase. Section HFS 35.08 (3) (c) is renumbered HFS 35.08 (2) (c).
46. 35.08 (4)	The proposed designation of "exceptional clinics" is biased toward large clinics, requires additional oversight, and creates an unnecessary and unacceptable two-tiered system of certification. "Other ancillary professional disciplines" is undefined and may prove to be problematic. Are lawyers ancillary in a practice that includes treatment of forensic work or personal trainers in a practice that includes treatment of eating disorders? 2, 3, 5, 15, 29, 37, 52, 75, 76, 79, 90, 99, 100	The Department is no longer considering an "exceptional clinic" designation. References to that designation have been removed from the rule. Section HFS 35.08 (4) is renumbered HFS 35.08 (3).
47. 35.08 (5) (c) 2.	The rule needs to be much more specific about the determination of a deficiency, the rationale/parameter for restrictions and the process for review of corrective steps. If a deficiency is significant enough to be cited, a 2 year period is too long to wait for correction. 99	Section HFS 35.08 (5) (c) 2., which allowed for a two year provisional certification was removed from the rule. Providers are to comply with all rule requirements at all times. Department surveyors issue a notice of deficiency based on their observations that a rule requirement has not been met.
48. 35.08 (6) (a)	Medicare and private insurance law do not require clinic status for all providers. DHFS	The commenter is correct, but no change is necessary because the rule does not require

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	cannot prohibit a clinic from deciding not to renew. The clinic can still function, simply not as a certified clinic. 99	clinics to renew certification. The rule only identifies the steps required to renew a clinic's certification. Section HFS 35.08 (6) (a) is renumbered 35.08 (4) (a) and (b).
49. 35.08 (6) (c)	A less intensive initial inspection or waiver of the initial on-site for the clinics accredited by a national accrediting body is desired. The ability to waive on-site inspections for clinics accredited by a national accrediting body is a welcome change. 92	The Department believes that it is important for the public's health, safety and welfare to determine whether a new clinic meets Wisconsin regulations. National accrediting bodies do not always emphasize the areas unique to Wisconsin. The Department may waive on-site inspections required for renewal certification for the reasons stated under s. HFS 35.08 (2) (d). Section HFS 35.08 (6) (c) is renumbered 35.08 (1) (b).
50. 35.11 (1)	Unannounced site visits disrupt clinic operations and should be prohibited. 15	Unannounced visits occur only when a complaint about a clinic's operation or performance has been received or a death investigation is necessary. Verification visits to determine if the clinic has corrected previous infractions generally are announced, as are certification surveys.
51. 35.11 (2) (b) 1.	DHFS may terminate clinic status, but cannot close a clinic; services may continue. Who is responsible to avoid abandonment of consumers? The Department needs to establish guidelines for these types of situations. 99	The Department has revised s. HFS 35.11 (2) to clarify that the Department may terminate certification if the Department finds that a clinic has a major deficiency, as defined under s. HFS 35.03 (9m), or may summarily suspend certification to protect the health, safety and welfare of consumers. The commenter is correct that the Department cannot close a clinic. However, termination of the clinic's certification for Medicaid and private insurance may cause a clinic to close due to lack of financial resources to continue operation. Sections HFS 35.23 (3) and 35.24 address the transfer or records and involuntary discharge of a consumer, respectively.
52. 35.12 (2) (a) and (b)	The rule needs to define personnel qualifications, data/evidence required to demonstrate alternatives and "unreasonable hardship". 99	In considering requests for waivers or variances, the Department will consider alternatives presented by a clinic in the manner prescribed under s. HFS 35.12 (2). The list of alternative categories is only illustrative of ideas that may be considered by the Department. If specific ideas are delineated or required, clinics and the Department would lose the flexibility that is necessary for innovation or unforeseen needs. The Department has revised s. HFS 35.12 (2) to remove the phrase "unreasonable hardship."

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53. 35.12 (4)	There should be appeal rights for the denial of an appeal or a revocation of a waiver or variance. 37	The Department has removed the sentence from s. HFS 35.12 (4) (a) indicating there are no appeal rights for denial or revocation of waivers or variances.
54. 35.13	Policies and procedures are not the function of the clinic or DHFS; this is the role of the Department of Regulation and Licensing. The requirement for extensive and detailed personnel policies is over codified. 5, 99	Implementing policies and procedures, particularly personnel policies and procedures, are a basic administrative function of any entity, including a clinic and its administrator. The rule prescribes neither the length nor breadth of the policies. The requirement under s. HFS 35.13 is to implement personnel policies. This requirement is minimal and only requires clinics to verify that staff persons meet license and training requirements; to conduct the caregiver background checks required under s. 50.065, Stats., and ch. HFS 12, and caregiver misconduct requirements under ch. HFS 13; and to maintain a personnel file for staff members.
55. 35.13 (3) (c) and (d)	Does this paragraph require that the personnel files contain all Department of Regulation Licensing documentation? It should be the responsibility of mental health professionals and practitioners, not agencies, to document in-service training requirements. 90, 99	The clinic needs the vita of training, work experience, and qualifications of prescribers and persons who provide psychotherapy to comply with the requirements under s. HFS 35.13 (1) for privileging staff. DRL's licensing requirements review whether a person has the minimum training and experience to qualify for licensure. DRL does evaluate if the training and experience is adequate for meeting the needs of consumers of a particular clinic, which is the intention of s. HFS 35.13 (1) and (3) (c) and (d). Section HFS 35.13 (3) (d) only requires the clinic, as part of its basic administrative functions, to maintain, in staff members' personnel files, documentation of the orientation and continuing training received by all of its staff members, including clerical, and other administrative staff.
56. 35.14	The rule states each clinic shall implement a written policy for clinical supervision, collaboration and consultation. The rule seems to imply that all three are required. The clinic should be free to choose one. A distinction needs to be maintained between supervision, collaboration, and consultation. Physicians and psychologists are not required to participate in clinical collaboration, clinical supervision, or seek clinical consultation. This requirement is an unwarranted intrusion for licensed professionals. In addition, the	Section HFS 35.14 was revised to remove the requirement for clinical consultation. Clinical supervision has been redefined to mean the supervised practice described under chs. MPSW 4, 12 or 16, or Psy 2, as applicable. Any staff member, including a substance abuse counselor, providing services to consumers who have a primary diagnosis of substance abuse must have clinical supervision, as defined under s. RL 160.02 (6), by a substance abuse counselor as described under ch. RL 162. Graduate

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	independent contractor cannot be subject to oversight, except in general terms. Supervision should be allowed to occur within the already established parameters of the Department of Regulation and Licensing and the law. Supervision should only be required on an as needed basis. A list of consultations received should be sufficient. Supervision should be required for all persons who are not licensed to provide MH and psychotherapy services independently. It is recommended that supervision or collaboration be with a licensed professional qualified to provide both substance abuse and mental health services. 2, 5, 15, 18, 26, 37, 82, 90, 97, 99	students and persons with a graduate degree in specified disciplines who have not met the supervised practice requirements under chs. MPSW 4, 12, 16, or Psy 2, as applicable, must receive clinical supervision as described in those administrative rules. Under the proposed rules, clinical supervision of mental health practitioners and recognized psychotherapy practitioners who provide psychotherapy is at the discretion of the clinic. The requirement for clinics to have policies for clinical supervision and clinical collaboration has been maintained. The extent of this requirement is that the policies address a system to determine status and achievement of consumer outcomes and a system to identify any necessary corrective actions. The proposed rules provide an illustrative list of methods of clinical collaboration that may be adopted under the clinic's policies for clinical collaboration. The list includes an option of choosing any other professionally recognized method of clinical collaboration that is designed to provide sufficient guidance to assure the delivery of effective services to consumers by staff members. Any additional clinical supervision imposed on staff is at the discretion of the clinic. The terms "staff" and "staff member" as defined in the rule includes individuals employed by the clinic, or under contract with the clinic. This means that independent contractors, under the rule, are subject to clinical supervision or clinical collaboration as applicable.
57. 35.14	Amend the rule to read, "Clinical consultation shall be dated and documented in the clinical record with the signature of the professional seeking/initiating consultation." The record of supervision, collaboration or consultation should be documented in the patient record only to avoid unnecessary duplication of records and possible breach of confidentiality. In case of trainees, documentation would be kept in the form required by Department of Regulation and Licensing or graduate school, rather than the DHFS. 35, 37, 75, 79, 90, 99	The requirement for "clinical consultation" has been removed from the rule. Recommendations for a change in a consumer's treatment plan should be documented in the consumer record. Otherwise, documentation of clinical collaboration and clinical supervision, and any staff issues raised may be more appropriately documented in a separate log or in a staff member's personnel record, on the applicable Department of Regulation and Licensing forms. Clinical collaboration and clinical

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		supervision records should not include consumer data or content that may treatment records. Section HFS 35.14 (5) has been renumbered s. HFS 35.14 (3).
58. 35.14	By definition, the administrator does not need to have clinical credentials, but is responsible for overseeing the job performance and actions of staff. 99	The rule requires a clinic administrator to be responsible for clinic operations, including ensuring compliance with ch. HFS 35 and other applicable state and federal law. The rule does not require the clinic administrator to provide clinical supervision or participate in clinical collaboration. Credentials of a clinic administrator may be determined at the discretion of the clinic.
59. 35.14 (1)	This requirement is too vague. We would not recommend that consumer satisfaction surveys become the basis for assessment of treatment effectiveness. 99, 100	Section HFS 35.14 (1) which has been renumbered s. HFS 35.14 (1) (b), does not require consumer satisfaction surveys. The provision only requires that a clinic's required written policy for clinical collaboration and clinical supervision address a system for determining the status and achievement of consumer outcomes, which may include a quality improvement system or peer review system to determine whether the treatment provided is effective, and a system to identify any necessary corrective actions. Adding additional specificity to this requirement would reduce the flexibility that may be needed by clinics and consumers.
60. 35.15	The requirement for training about recovery concepts, use of strengths based approach to assessment and treatment planning and consumer being at the center of planning and involvement is strongly supported. 22, 131	No response necessary.
61. 35.15	This section is over codified and requires separate training records be documented by the clinic. 5, 15, 100	Section HFS 35.15 has been revised to eliminate many of the specific requirements. The remaining provisions outline the knowledge and skill areas, such as suicide prevention, and the potential side effects of psychotropic drugs, that staff must possess to be able to meet the needs of consumers. Training related to these issues is not specifically addressed in licensing regulations for the various mental health professions, including advanced practice nursing.
62. 35.15 (1) (intro.)	The term "job function shall be the determining factor" is too vague. Distinguish between what training is required for specific jobs and the extent of background in similar work settings. 99	Section HFS 35.15 (1) has been renumbered s. HFS 35.15 (2), and revised to incorporate the commenter's suggestion.
63. 35.15 (1) (e)	The rule should be modified to take effect only when the population being served is unique and/or unknown to the staff person.	The rule only requires that staff new to the clinic be trained to meet the needs of the consumers being served by the clinic. The

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	Otherwise, the generic statement is insulting. 99	population in general includes varying demographics that may have cultural factors unique to that group and unknown to the staff member new to the clinic. The Department believes that a staff member's knowledge of this information may enhance the services provided by the clinic for the particular demographic. Section HFS 35.15 (1) (e) has been renumbered s. HFS 35.15 (2) (b) 3.
64. 35.15 (1) (i)	The rule also should include signs and symptoms most relevant to treatment of substance use disorders, which may or may not have been identified as a presenting problem. 99	Section HFS 35.15 (1) (i) has been renumbered s. HFS 35.15 (2) (b) 4. and revised to incorporate the commenter's suggestion.
65. 35.15 (1) (i) to (L)	These training issues are part of the graduate school education, continuing education and initial treatment experience required for professional licensure. 79	Graduate schools do not uniformly provide training and education in these areas and, if so, may be addressed only in elective courses. Also, an individual who moves to Wisconsin from another state may not have taken such courses. In addition, the continuing education requirements under chs. MPSW 8, 14, and 19 and Psy 4 are dissimilar, general in nature, and do not address the specific content areas under s. HFS 35.15 (1), which is renumbered s. HFS 35.15 (2) (b).
66. 35.15 (2)	The rule requires training for new staff, but does not address ongoing training other than to state that licensed or certified professionals must receive the number of hours required to maintain their license or certification. Adding a requirement that some of this ongoing training must address key issues such as recovery concepts, community resources, treatment for dual disorders, suicide assessment and treatment, evidence based practices, and/or trauma would strengthen this provision. 131	The Department has replaced the requirement that licensed or certified professionals receive continuing education to maintain licensure with a more general requirement that the clinic ensures staff members receive initial and continuing training that enables the staff member to perform the staff member's duties effectively, efficiently and competently. The Department believes that this general requirement will be sufficient to assure consideration of the orientation requirements. Clinics will be better able to tailor their ongoing training program to meet the needs of the clinic's staff members and consumers using this more general approach. Section HFS 35.15 (2) is renumbered s. HFS 35.15 (1).
67. 35.15 (2) (b)	This assumes that such training can be compared with formal continuing education required for licensure. It imposes additional financial burden on the clinic. Who will determine what training is appropriate for each practitioner? 99	The requirements for continuing education for mental health professionals and mental health practitioners have been removed from the rule. A clinic, under s. HFS 35.15 (1), is required to ensure that each staff member, which include mental health professionals and mental health practitioners, and advanced practice nurses practicing psychotherapy,

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		receive initial and continuing training that enable the staff member to perform the staff member's duties effectively, efficiently, and competently.
68. 35.16	We support the requirement for a referral when the clinic does not have the required expertise to address substance abuse treatment needs. We urge that this requirement be added for persons with other dual diagnosis issues. There should be a requirement that if a consumer needs and desires trauma specific treatment and the clinic cannot provide trauma specific services, then there must be a referral to another provider. While the rule does require a clinic to identify admission priorities and waiting list procedures, we believe that the rule should require that persons being transitioned to the clinic from inpatient care be given priority status. 22, 131	The Department has revised s. HFS 35.17 (2), to require a clinic to refer a consumer to an appropriate provider if the clinic, independently or in collaboration with other providers, cannot serve the consumer's needs. The Department agrees with the value of a priority for admission for persons being discharged from an inpatient psychiatric hospital unit, however, the Department believes it is inappropriate to impose such a requirement on private providers. In addition, this concept may be difficult for clinics operated by counties to implement given the limitations on county responsibilities under s. 51.42 (1) (b), Stats.
69. 35.16 (1)	What purpose is there to estimate the amount of time the person will be in psychotherapy? 35	The length of treatment is a component of the consumer's right under s. 51.61 (1) (w), Stats., and s. HFS 94.03 (2) to be informed of costs for services and the right to receive information about the charges for services. Section HFS 35.16 (1) has been renumbered s. HFS 35.16 (4) (a).
70. 35.16 (1) (a)	Who is qualified to diagnose? 99	Section HFS 35.16 (1) (a) has been renumbered s. HFS 35.16 (4) (a) and revised to indicate that in a clinic, only a licensed treatment professional, or a recognized psychotherapy practitioner if within the lawful scope of practice under s. 457.02 (6) (a), Stats., may diagnose mental illness of a consumer. Section HFS 35.16 (1) (a) was renumbered as HFS 35.16 (4) (a).
71. 35.16 (1) (b)	Requiring a physician prescription should be deleted. Are there exceptions? If so, they should be specified. No one likes this requirement. 96, 99	A physician prescription for Medicaid recipients to receive psychotherapy is required under s. 49.46 (2) (b) 6. f., Stats. There are no exceptions to this requirement under the statute. The Department does not have the legal authority to change a statutory requirement in administrative rules. The proposed rules do not require a physician prescription for non-Medicaid eligible consumers to receive psychotherapy services. Section HFS 35.16 (1) (b) has been renumbered s. HS 35.16 (4) (b).

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72. 35.16 (2) (b)	Use of approved placement criteria is not necessary for some consumers. It is inappropriate in mental health clinic rules and it assumes familiarity with AODA placement criteria. This requirement assumes the consumer will provide the information. 37, 35, 99	Under s. HFS 35.123 (4) (b), if a clinic's staff does not include an individual who has knowledge and skills to provide substance abuse assessments and services, the clinic is required to have a written referral agreement with an individual or entity to provide such services. Section HFS 35.16 (2) (b) is renumbered s. HFS 35.16 (5) and only requires the use of an approved placement criteria tool to determine if a consumer who has a co-occurring substance use disorder needs substance use services and a referral of a consumer to an appropriate Department certified provider if the consumer is determined to need a level of substance use services that are above the level that can be provided by the clinic. Information necessary to make this determination may come from the consumer, direct observation, or other sources.
73. 35.16 (3)	Reword to allow certain discriminations based on specializations of the clinic and its clinicians. 99	Section HFS 35.16 (3) which has been renumbered s. HFS 35.16 (1) allows clinic specialization as an admissions screening tool.
74. 35.16 (6) (a)	Would being "on-call" be sufficient for being available? 108	Having someone "on-call" who knows the consumer or can reach the therapist for information, as necessary, would be an acceptable means of meeting the requirement for arranging for emergency mental health services or crisis services to the clinic's consumers. Section HFS 35.16 (6) (a) has been renumbered s. HFS 35.165 (1).
75. 35.17	The admission and assessment requirements are extremely codified. 5, 15, 117	The Department believes that the admission and assessment requirements under ss. HFS 35.16 and 35.17, respectively, are basic minimum requirements that are necessary for the protection of consumers, particularly concerning access and treatment needs. For example, s. HFS 35.16 is a guide to clinics in the clinic's establishment of the required written admissions criteria; policies for referrals and waiting list priorities; and documentation of the consumers' need for psychotherapy. Section HFS 35.17, relating to assessments are minimum requirements for basic information that should be collected from a consumer seeking mental health services.
76. 35.17	Gender issues should be addressed in assessment, treatment planning, and initial and ongoing training. The Lt. Governor's	The Department acknowledges that there is a need for mental health professionals to be proactive in addressing gender specific needs,

	Task Force on Women and Depression has identified the critical need for treatment to address gender issues in order to meet the needs of women. 22, 131	particularly related to women, however, the Task Force report contains few, if any, specific recommendations to changes that should be made in providing outpatient mental health services. As a result, it is difficult to codify specific requirements that should be added to the proposed rule.
77. 35.17 (1) (a)	We strongly support the requirements that dual problems, such as mental health and substance abuse or mental health and developmental disability, be addressed in assessments and treatment planning and that the clinic must demonstrate its staff is competent to address these issues. 131	No response necessary.
78. 35.17 (1) (a)	The requirement for completion of an initial assessment before the second meeting, including consumer strengths and goals for recovery is unnecessary and redundant micro-management. Most consumers do not want to be seen as a diagnosis and are not ready to discuss goals. 5, 7, 15, 35, 99	The Department revised s. HFS 35.17 (1) (a) and (b) to distinguish between an initial and comprehensive assessment to better clarify the Department's intent for clinics to collect information sufficient to identify the consumer's need for outpatient mental health services during the initial meeting and that a comprehensive assessment be completed before developing an initial treatment plan.
79. 35.17 (1) (a)	We recommend the wording in this section be changed to, "An initial assessment would include consumer's presenting problems with the onset and course of symptoms, past treatment response, and the current manifestation of the presenting problem." A completed assessment would include a strength-based assessment and a differential diagnostic examination. 35, 75	See the response to comment #78.
80. 35.17 (1) (a) 2.	Change the last sentence in the paragraph to read, "A consumer who is identified as chemically dependent or alcohol dependent shall be referred to a program that is certified under ch. HFS 75 unless the outpatient mental health clinic has a substance abuse counselor who provides consumer services." Act 80 allows licensed professionals to diagnose and treat addictions. Should not need to refer out. 35	The requirement has been replaced by a note that references s. HFS 35.123 (4) (b) and s. HFS 35.16 (5), which requires clinics to have a written referral agreement only if clinic staff does not include an individual who has knowledge and skills to provide substance abuse assessments and services. If the consumer is determined to need a level of substance use services that are above the level of substance use services that can be provided by the clinic, the consumer shall be referred to an appropriately Department certified provider. Section HFS 35.17 (1) (a) 2. is renumbered s. HFS 35.17 (1) (b) 2.
81. 35.17 (1) (a) 2.	Requiring GAF number and Axis 4 category does not improve the information in the record. 79	References specifying categories for assessment have been removed. Section HFS 35.17 (1) (a) 2. is renumbered s. HFS 35.17 (1) (b) 2.
82. 35.17 (1) (a) 2.	Specify who is authorized to diagnose. 99	The Department has revised s. HFS 35.16 (4) (a) to indicate who may diagnose a mental illness of a consumer. Section HFS 35.17 (1)

		(a) 2. is renumbered s. HFS 35.17 (1) (b) 2.
83. 35.17 (1) (b)	Exclude the words "strengths including;" strengths have no place in this body of information. 96	Clinical literature indicates that building upon a person's strength and existing skills is an essential component of appropriate treatment and is effective in terms of achieving a consumer's treatment outcomes. Section HFS 35.17 (1) (b) is renumbered HFS 35.17 (1) (b) 4.
84. 35.18 (1) (intro.)	We object to providing consumer rights information at the first meeting. 5, 7	Section HFS 35.18 does not specify when consumers should be notified of their consumer (patient) rights. Section 51.61 (1) (a), Stats., and ch. HFS 94, however, require, in part, that each consumer, upon admission or commitment be informed orally and in writing of his or her rights under s. 51.61, Stats.
85. 35.18	Object to informing consumers of policies on privacy, assessment, consultation, grievance and informed consent, signing documents and agreeing to the possibility of state review of clinical records. The consent for treatment requirements exceeds those of many other professionals. 5, 7, 9, 90	Sections 51.30 and 51.61, Stats., and chs. HFS 92 and 94 set forth the requirements for notifications of consumer (patient) rights, which treatment facilities (including outpatient mental health clinics) are required to follow. The notifications required under the proposed rules are consistent with, and do not exceed those requirements.
86. 35.18 (1)	What does, "informing the consumer or the consumer's representative of results of the assessment in writing," mean? Professionals should be given the authority to choose which consents are appropriate under which circumstances. 37, 99	Section HFS 35.18 (1) has been revised to clarify that a copy of the assessment or a written summary of the assessment given to the consumer, parent, or legal representative will satisfy the requirement to inform the consumer, parent, or legal representative of the results of the assessment. Sections 51.30 and 51.61, Stats., specify the content areas for which consent is required.
87. 35.18 (2)	Change the last word in the paragraph from "treatment" to "outpatient mental health services." 75 Need to inform consumers of limits on confidentiality of court-ordered services, all consumers should be informed of mandatory reporting in case of abuse, threats to harm to others, etc. 99	The proposed rule language has been revised in accordance with the comment. Limits on confidentiality of court ordered services and issues related to mandatory reporting are exceptional circumstances and are already governed under statute. It would be appropriate to inform the consumer for whom this would apply, but it is not necessary to include this in the rule because these issues are already addressed in the statutes. In addition, where discretion is allowed under statute, clinics can individually determine whether consumers should be informed of mandatory reporting.
88. 35.18 (3) (a)	Eliminate this paragraph; consent for treatment covers this area. 35	Section HFS 35.18 (3) (a) has been removed from the rule.
89. 35.19	DHFS could require an alternate plan of action that would document services provided	If a clinic provides services, such as life coaching, etc., as opposed to treatment for

	for consumers not receiving treatment. 99	psychotherapy, it is in the clinic's discretion as to whether the clinic provides such services and whether to develop a plan for providing those services to a consumer. The rule does not prohibit a plan for such services.
90. 35.19	The nature of psychotherapy is more shifting and evolving and detailed treatment planning before treatment begins is difficult to accomplish. 5, 7, 18	The Department believes treatment planning is necessary to determine appropriate treatment steps and is essential to comply with the consumer's right to participate in treatment planning. The rule requires an initial treatment plan, and anticipates under s. HFS 35.19 (3) that the treatment plan may change as treatment progresses.
91. 35.19 (1) (a) 1.	Looking at treatment outcomes, etc. is unreasonable. 12	Outpatient treatment services are provided to improve the mental health of consumers. The monitoring of desired outcomes is to determine if the symptoms causing the consumer's problems or inability to function in day to day living have been reduced and if the consumer's ability to function as independently as possible has increased. Monitoring treatment outcomes will alert the therapist to possible needs for changes in the treatment plan.
92. 35.19 (1) (a) 1.	Strengths should be used according to the professional's discretion, not mandated by statutes. 91	The rule does not mandate how consumer strengths should be used. Section HFS 35.19 (1) (a) 1. only requires documentation of the consumer's strengths and documentation of how the psychotherapist will use those strengths in the consumer's treatment to achieve measurable outcomes.
93. 35.19 (1) (a) 4.	The term, "irrespective of availability of services and funding," needs to be defined to show where responsibility of the clinic ends. 99	The Department does not believe a change is necessary. Section HFS 35.19 (1) (a) 4., is explicit in its requirement for a treatment plan that describes the schedules, frequency, and nature of services recommended whether or not the services are available at the clinic, or whether there is funding available to pay for the services. The intent is to describe the treatment needed by a consumer without consideration of availability of services or ability of the consumer to pay or receive third party payer funding to pay for the services. As required under ss. HFS 35.16 (2) and (5), and 35.17 (2), a clinic should refer a consumer to an appropriate provider if the clinic cannot provide the services needed by the consumer.
94. 35.19 (2)	Recommend changing the first sentence to read, "As outpatient … etc." instead of "Before outpatient …" 75	Section HFS 35.19 (2) has been revised in accordance with the comment.

95. 35.19 (3) (intro.)	This requirement for clinical review constitutes micromanagement of the treatment process. The method of review and consumer involvement should be left to professional judgment and consumer choice. 37, 79	In terms of consumer choice, the provision has been revised to clarify that the clinic under s. 51.61 (1) (fm), Stats., must give the consumer the opportunity to participate in the review. Section HFS 35.19 (3) only requires clinics to conduct a clinical review, prescribes the intervals in which clinical review should be conducted, and lists the minimum requirements for documentation of the review. The method or process for clinical review is to be established by clinic staff.
96. 35.19 (3) (b)	The rule should be specific about how any change in diagnosis plays into the review of treatment plan, and if a parent or court consents to the change. 99	The Department does not believe a change is necessary. HFS 35.19 (3) (b) (intro.) requires staff to establish a process for the review of the consumer's treatment plan and progress toward measurable outcomes. This requirement and s. HFS 35.19 (3) (b) 2. anticipate that changes in diagnosis may occur and may or may not indicate changes in the treatment plan are necessary. Consequently, the clinical review process should identify and address issues related to changes in diagnoses and progress towards outcomes. Section HFS 35.19 (1) and (2) address who can provide consent for treatment.
97. 35.19 (3) (b)	Requiring a signed review and treatment plan every 6 sessions or 90 days is absurd. The consumer should not be required to sign the review. 5, 7, 35, 37, 79, 84, 93, 100, 109	The rules relating to informed consent under s. HFS 35.19 (2) have been revised to require the clinic to obtain the consumer's written consent in accordance with s. HFS 94.03 (1). Section HFS 94.03 (1) f., requires informed consent to be renewed at least every 15 months.
98. 35.20 (2)	The rule needs clarification; it should say, "the consumer shall be referred." 34, 99	Section HFS 35.20 (2) has been revised to clarify the provision.
99. 35.20 (3)	The rule needs clarification; it should read, "the clinic shall document all medications provided by the clinic and used by the consumer as part of their mental health treatment." 34, 99	Section HFS 35.20 (3) has been revised to clarify the provision.
100. 35.21 (1)	There is a debate in the mental health field as to whether evidence based interventions or empirically validated treatments are actually preferable and necessarily more efficacious in community settings. Also, the degree to which the therapist believes therapy is efficacious account for a far greater proportion of the variance in outcome than a particular modality of treatment or specific intervention. 28, 31, 37, 99	If a clinical intervention is not evidence-based (i.e., predicated on government or professional organization guidelines, or research published in a peer-review journal), then the intervention may be considered experimental. Experimental approaches require more stringent informed consent and may not be reimbursable by third party payers. The Department is concerned with consumer outcomes. Under the proposed rules, clinics have discretion to choose the

		treatment methods that the clinic believes will lead to the desired consumer outcomes. The final decision on the selection of treatment approaches for a specific consumer should be made by the consumer's therapist in accordance with the clinic's policy and the informed consent of the consumer.
101. 35.21 (2)	This paragraph should be deleted. This language is stated in earlier sections. Neither the clinic nor the Department can require that a consumer receive services. 99	Section HFS 35.21 (2) has been reworded to require clinics to *make reasonable efforts* to ensure consumers receive the recommended interventions consented to by the consumer.
102. 35.21 (3)	This paragraph dealing with requirements related to group therapy should be placed elsewhere. 99	Section HFS 35.21 (3) has been renumbered s. HFS 35.215, which places the requirements for group therapy in its own section.
103. 35.22	Providing a discharge summary within 30 days of conclusion of treatment is almost impossible. 26	Discharge for a consumer who was voluntarily admitted to a clinic means, under the proposed rule, termination of treatment obligations between the patient and the clinic. The clinic makes the determination of when treatment obligations are concluded. The clinic, therefore, has control over when the discharge summary needs to be completed.
104. 35.22 (1) (d)	The rule should address consumers who simply drop out of treatment (e.g., deactivate). 99	The clinic determines when a person is discharged whether the discharge is voluntary or involuntary. The rule has been revised, however, to clarify that the therapist summarize, in the discharge summary, the therapist's final evaluation of the consumer's progress toward the goals of the treatment plan and any remaining consumer needs at the time of discharge and the recommendations for meeting those needs, including the names and addresses of any facilities, persons or programs to which the consumer was referred for additional services following discharge.
105. 35.23 (2)	Oversight of the clinical records of licensed professionals, which is done by the Department, is counter to the ethics of most professional organizations. Private consumers want privacy and flexibility determined by them and the therapist, not the Department. The type of consumer record notes required is objectionable.5, 7, 9, 15, 23, 27, 31, 77, 15, 118	HIPPA and s. 51.30, (4) (b) Stats., and s. HFS 92.04 (5) allow access by the Department to treatment records for such activities as program evaluation and progress and adequacy of treatment. A definition for treatment records has been included in the proposed rule. This definition is the same definition as under s. 51.30 (1) (am) and (b), Stats., and s. HFS 92.02 (16). The documentation requirements for treatment records under s. HFS 35.23 (2) are basic recordkeeping requirements and do not exceed the requirements under the definition of treatment records. Section HFS 35.23 (2) has been renumbered s. HFS 35.23 (1).
106. 35.23 (2) (a) 9.	Strike this section and substitute wording that validates a legally sufficient "informed	The Department believes that the requirements in rules concerning informed

	consent" and mandates detail sufficient for the consumer to understand their obligations. 80	consent are sufficiently addressed. The intent of s. HFS 35.23 (2) (a) 9. is only to require documentation of consumers'consent, and any court orders received by the clinic to be maintained in the consumer's treatment record. Section HFS 35.23 (2) (a) 9. was renumbered as HFS 35.23 (1) (a) 9.
107. 35.23 (2) (a) 10.	Keeping a medications list current is an onerous task for a small clinic. 12, 13	Section HFS 35.23 (2) (a) 10. which has been renumbered s. HFS 35.23 (1) (a) 10., only requires documentation of medication prescribed and dispensed or administered by clinic staff members. Therefore, if a clinic does not prescribe or administer medication, a list of medication is not required under the rule.
108. 35.23 (2) (b)	This paragraph regarding composite record for a family receiving treatment is too simply stated and does not address potential problems. 99	Section HFS 35.23 (2) (b), which has been renumbered 35.23 (1) (b), is only intended to indicate to clinics that it is acceptable to the Department to keep composite treatment records of a family in treatment as a unit, and reminds clinics that individual confidentiality should be maintained if records are released. The rule has been revised, however, to better clarify that if information is released, provisions shall be made for individual confidentiality pursuant to s. 51.30, Stats., and ch. HFS 92.
109. 35.23 (3) (a)	"Accessible to staff at all times" is problematic since some staff persons should not have access at all times. 99	Section HFS 35.23 (3) (a) and (b) have been consolidated as s. HFS 35.23 (2) and revised to indicate records be accessible to *appropriate* staff members at all times.
110. 35.23 (3) (c)	How are psychotherapy notes used in supervision etc. if they need to be kept separate from the record? 99	Section HFS 35.23 (3) (c) has been removed from the rule and replaced with a note to inform therapists that if notes or records, recorded in any medium, maintained for personal use by an individual providing treatment services are available to others, the notes or records become part of the treatment records. See s. 51.30 (1) (b), Stats., and ss. HFS 92.02 (16) and 92.03 (1) (b).
111. 35.23 (4)	Transfer should only be made to qualified professionals not to a facility. 99	Section HFS 35.23 (4) is renumbered s. HFS 35.23 (3) and revised to allow transfers of consumer records from a mental health professional to another mental health professional, another clinic, or another mental health program (e.g., community support program).
112. 35.23 (5) (a)	Retention of records must also be in accordance with other laws, etc. It would be useful to specify what should be removed from records at certain intervals and method of destruction. 99	Section HFS 35.23 (5) (a) is renumbered s. HFS 35.23 (4) (a) and revised to indicate that the clinic's written policy on retention of consumer records must be in accordance with s. HFS 92.12 and other applicable laws.
113. 35.23 (6) (a)	The term, "provider" should not be used	Section HFS 35.23 (6) (a) is renumbered s.

	unless defined. 99	HFS 35.23 (5) (a) and revised to remove the term "provider".
114. 35.23 (6) (b)	Add transmission must comply with HIPAA. 99	The Note to s. HFS 35.23 (6) (b) already advises that transmission of information must comply with HIPAA, s. 51.30 and ch. HFS 92. Section HFS 35.23 (6) (b) is renumbered s. HFS 35.23 (5) (b).
115. 35.23 (6)	The method of producing, storing and retiring the electronic backup file should also be subject to HIPAA. 99	All treatment records, including those maintained electronically, must meet the requirements under s. HFS 35.23 (2) to (4) relating to storing, retention, and transferring treatment records. These provisions include consideration of 45 CFR Parts 160, 162 and 164, the federal HIPAA security and privacy regulations. Section HFS 35.23 (6) (d) is renumbered s. HFS 35.23 (5).
116. 35.24 (3) (a) 2.	Add, "welfare of individuals," to "safety of individuals." 99	Section HFS 35.24 (3) (a) 2. was renumbered as HFS 35.24 (3) (b) 2. and revised to read, "In cases of discharge for behavior that is reasonably a result of mental health symptoms, whether the consumer's needs can be met by the clinic, whether the safety of staff or other consumers of the clinic may be endangered by the consumer's behavior, and whether another provider has accepted a referral to serve the consumer." The Department believes the term, "welfare," is too vague and may allow involuntary discharge of consumers because the consumer may bother staff or other consumers.
117. HFS 105.22 (1) (bm)	The references limit provision of psychotherapy to only advance practice nurse prescribers, many advance practice nurses are psychiatric specialists, but are not prescribers. They should be included. 83	See the response to comment #118.
118. HFS 105.22 (1) (c)	This limits the provision of psychotherapy to only advance nurse prescribers. Many advance practice nurses have psychiatric specialties and are not prescribers. This section should be modified by replacing, "Prescriber licensed under ch. 441.01 (3), Stats., certified under ch. 441.16, Stats.," with "An advanced practice nurse under ch. 441 and is currently certified as having a psychiatric specialty by the American Nurses Credentialing Center." 8, 36, 83, 116	Section HFS 105.22 (1) (c) does not limit the provision of psychotherapy to only advance nurse prescribers. Medicaid currently reimburses for psychotherapy services provided by advance practice nurses who have psychiatric specialties, who are not prescribers within an outpatient mental health clinic, as master's level therapists. This policy will not change with this proposed rule. The intention of the proposed rule is to bring advanced practice nurse prescribers (with psychiatric specialties) in parity with advanced practice nurse prescribers in other specialty areas by allowing them to be reimbursed independently. Currently prescribers with the psychiatric specialties are reimbursed under waiver.

		Aside from clinics, Medicaid also reimburses psychiatrists and Ph.D. psychologists in private practice for outpatient mental health services, which includes diagnostic evaluations and psychotherapy. In this revised rule, Medicaid is allowing advanced practice nurse prescribers with a psychiatric specialty in private practice to be reimbursed independently. This solidifies the present waivers granted to these providers to practice in lieu of a psychiatrist. These advanced practice nurse prescribers with a psychiatric specialty are not included in Medicaid's nurse practitioner benefit since mental health/substance abuse services must be covered under HFS 107.13. Thus, this addition treats these providers in the same way as other advance practice nurse prescribers, but in HFS 107.13.
119. HFS 105.22 (2)	Allows a lower standard for staffing than for free-standing clinics. The staff must be licensed by the Department of Regulation and Licensing and not just certified by the Department of Health and Family Services. 99	The word "certified" means Medicaid certified in this instance. These individuals still must be licensed.
120. HFS 105.22 (2) (b)	These individuals must also meet the requirements of the Department of Regulation and Licensing (i.e., be licensed). 99	No change is necessary. Section HFS 105.22 (2) (b) requires a person eligible to provide psychotherapy under s. HFS 105.22 in an outpatient mental health clinic to meet the applicable requirements under ch. HFS 35. Section HFS 105.22 (2) (b) appropriately cross-references to ch. HFS 35, which gives qualifications for persons who provide psychotherapy, and recognizes the licensure requirements of Department of Regulation and Licensing.
121. HFS 105.22 (3)	The switch to use of provider in combination with certified is confusing. 99	The word "certified" means Medicaid certified in this instance.
122. HFS 107.13 (2) (a) 1.	This is inappropriate in regulations for outpatient clinics because it prescribes one specific philosophy of treatment, restricts professional judgment, and precludes the availability of services that employ a variety of treatment approaches. 37	Section HFS 107.13 (2) (a) specifies the conditions under which psychotherapy is a covered MA service. The elements identified, including requirements for assessments are basic elements that are common to many philosophies, and are consistent with national standards of practice. In addition, federal MA regulations require that only activities that are medically necessary be reimbursable. The assessment and diagnostic evaluation prescribed helps determine the medical necessity for treatment. The provision does not limit, or promote or prescribe a philosophy of

		treatment.
123. HFS 107.13 (2) (a) 1.	Define who is qualified to perform differential diagnostic exam. 99	The Department does not believe the definition requested is necessary. Section HFS 107.13 (2) (a) specifies the conditions under which outpatient mental health services are covered by MA. Section HFS 107.13 (2) (a) 1., indicates, in pertinent part, that outpatient mental health services are covered when strength-based assessments, including a differential diagnostic examination, is performed by a MA certified psychotherapy provider. Section HFS 105.22 (1) specifies MA certified providers and is being revised in the proposed rule to include advanced practice nurse prescribers with a psychiatric specialty, and an outpatient mental health clinic that meets the requirements under ch. HFS 35. Under ch. HFS 35, mental health professionals, and advance practice nurses qualified under s. HFS 35.05 (1) (c), may provide psychotherapy, including diagnosis and treatment within a clinic.
124. HFS 107.13 (2) (a) 4. a.	This section should be corrected by deleting "prescriber" and instead read "or licensed and certified advance practice nurse." 8, 36, 83	See response to comment #118.
125. HFS 107.13 (3) (a) 7.	Since review of treatment plans allows for re-assessment, some provision for this should be made in the statement of reimbursement limitations. 99	The Department interprets this comment as requesting the Department to create an exception to the limits on reimbursements before prior authorization is required. This is not feasible due to MA budget limitations. Reassessment is a part of ongoing psychotherapy. This is nationally recognized. The American Medicaid Association does not issue a separate procedure code for reassessment.