

RIDER E

PROGRAM REQUIREMENTS **(SAMHS- SUBSTANCE ABUSE SERVICES)**

CLIENT ELIGIBILITY

1. All individuals experiencing problems with substance abuse are eligible for treatment services without regard to income. A fee may be charged in accordance with an approved fee schedule or residential rate established by the Provider.
2. Providers shall give preference to pregnant women and women with dependent children who seek treatment and shall publicize the availability of such services. The Provider also agrees to refer the woman to SAMHS if the treatment facility is at 90% capacity.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) FUNDS

§ 96.127 Requirements Regarding Tuberculosis (TB)

1. The program must, directly or through arrangements with other public or nonprofit private entities, routinely make available the following TB services to each individual receiving treatment for substance abuse:
 - (a.) Counseling the individual with respect to TB
 - (b.) Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual
 - (c.) Appropriate medical evaluation and treatment for individuals infected by mycobacteria TB
2. For clients denied admission to the program on the basis of lack of capacity, the program must refer such clients to other providers of TB services.
3. The program must have infection control procedures that are consistent with those established by Maine Centers for Disease Control to prevent the transmission of TB and that address the following:
 - (a.) Screening patients and identifying those individuals who are at high risk of becoming infected
 - (b.) Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2
 - (c.) Case management activities to ensure that individuals receive such services
4. The program must report all individuals with active TB to the Maine Centers for Disease Control as required by State law and in accordance with Federal and State confidentiality requirements, including 42 CFR part 2.

§ 96.131 Treatment Services for Pregnant Women

1. The program must give preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services.
2. If the program is an SAPT Block Grant-funded program that serves an injecting drug abusing population, the program must give preference to treatment as follows:
 - (a.) Pregnant injecting drug users
 - (b.) Other pregnant substance abusers
 - (c.) Other injecting drug use
 - (d.) All others
3. The program must refer pregnant women to the State when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program.
4. The program must make interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.
5. The program must offer interim services, when appropriate, that include, at a minimum^[1], the following:
 - (a.) Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur
 - (b.) Referral for HIV or TB treatment services, if necessary
 - (c.) Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women

§ 96.132 Additional Requirements

1. The program must make continuing education in substance abuse treatment and prevention available to employees who provided the services.
2. The program must have in effect a system to protect patient records from inappropriate disclosure, and the system must:
 - (a.) Comply with all applicable State and Federal laws and regulations, including 42 CFR part 2
 - (b.) Include provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure

^[1] Interim services may also include federally approved interim methadone maintenance.

§ 96.135 Restrictions on the Expenditure of the Grant

1. The program cannot expend SAPT Block Grant funds to provide inpatient hospital substance abuse services, except in cases when each of the following conditions is met:
 - (a.) The individual cannot be effectively treated in a community-based, nonhospital, residential program
 - (b.) The daily rate of payment provided to the hospital for providing the services does not exceed the comparable daily rate provided by a community-based, nonhospital, residential treatment program
 - (c.) A physician makes a determination that the following conditions have been met:
 - (i.) The primary diagnosis of the individual is substance abuse and the physician certifies that fact
 - (ii.) The individual cannot be safely treated in a community-based, nonhospital, residential treatment program
 - (iii.) The service can reasonably be expected to improve the person's condition or level of functioning
 - (iv.) The hospital-based substance abuse program follows national standards of substance abuse professional practice
 - (d.) The service is provided only to the extent that it is medically necessary (e.g., only for those days that the patient cannot be safely treated in a residential, community-based program)

2. Further, the program cannot expend SAPT Block Grant funds to:
 - (a.) Purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.
 - (b.) Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.
 - (c.) Provide financial assistance to any entity other than a public or nonprofit private entity
 - (d.) Make payments to intended recipients of health services.
 - (e.) Provide individuals with hypodermic needles or syringes.
 - (f.) Provide treatment services in penal or correctional institutions of the State.

§ 96.137 Payment Schedule

The program must ensure that SAPT Block Grant funds for special services for pregnant women and women with dependent children, TB services, and HIV early intervention services are the "payment of last resort" and the program must make every reasonable effort to do the following to pay for these services:

1. Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.

2. Secure from patients or clients payments for services in accordance with their ability to pay.

Single State Audit

1. If the program has \$500,000 or more in Federal expenditures during the program's fiscal year, the program must receive a single State audit.
2. If the program is a non-Federal entity with \$500,000 or more in Federal expenditures, the program may elect to have a program specific audit if both of the following conditions are met:
 - (a.) The expenditures are under only one Federal program.
 - (b.) The Federal program does not require an A-133 audit
3. If the program is a non-Federal entity that expends less than \$500,000 during the program's fiscal year, the program must retain records to support expenditures and must make those records available for review or audit by appropriate officials of the Federal Agency, the pass-through entity, and the General Accounting Office.

Salary Limitation

The program cannot use the SAPT Block Grant to pay salaries in excess of Level I of the Federal Senior Executive pay scale.

Charitable Choice

1. If the program is an SAPT Block Grant-funded program that is part of a faith-based organization, the program may:
 - (a.) Retain the authority over its internal governance
 - (b.) Retain religious terms in its name
 - (c.) Select board members on a religious basis
 - (d.) Include religious references in the mission statements and other governing documents
 - (e.) Use space in its facilities to offer Block Grant-funded activities without removing religious art, icons, scriptures, or other symbols
2. If the program is an SAPT Block Grant-funded program that is part of a faith-based organization, the program cannot use SAPT Block Grant funds for inherently religious activities such as the following:
 - (a.) Worship
 - (b.) Religious instruction
 - (c.) Proselytization
3. The program may only engage in religious activities listed under 2. Above if both of the following conditions are met:
 - (a.) The activities are offered separately, in time or location, from Block Grant-funded activities
 - (b.) Participation in the activities is voluntary

4. In delivering services, including outreach activities, SAPT Block Grant-funded religious organizations **cannot** discriminate against current or prospective program participants based on:
 - (a.) Religion
 - (b.) Religious belief
 - (c.) Refusal to hold a religious belief
 - (d.) Refusal to actively participate in a religious practice
5. If an otherwise eligible client objects to the religious character of the program, the program shall refer the client to an alternative provider within a reasonable period of time of the objection.
6. If the program is a religious organization, the program must:
 - (a.) Use generally accepted auditing and accounting principles to account for SAPT Block Grant funds similar to other nongovernmental organizations.
 - (b.) Segregate Federal funds from non-Federal funds.
 - (c.) Subject Federal funds to audits by the government.
 - (d.) Apply Charitable Choice requirements to commingled funds when State/local funds are commingled with Block Grant funds.

§ 96.124 Certain Allocations: (Required Services for Programs Receiving Block Grant Funds Set Aside for Pregnant Women and Women with Dependent Children)

If the program receives SAPT Block Grant funds set aside for special services for pregnant women and women with dependent children (including women attempting to regain custody of their children), the program must provide or arrange for the following:

1. Primary medical care, including prenatal care, for women who are receiving substance abuse services.
2. Childcare while the women are receiving services.
3. Primary pediatric care for the women's children, including immunizations.
4. Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
5. Therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
6. Sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (1.) through (5.) above.

The program must also treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate.^[2]

^[2] Such an admission may not be appropriate, however, if, for example, the father of the child(ren) is able to adequately care for the child(ren).

§ 96.126 Capacity of Treatment for Intravenous Drug Abusers

If the program treats injecting drug users, the program must:

1. Within 7 days, notify the State whenever the program has reached 90 percent of its treatment capacity.
2. Admit each individual who requests and is in need of treatment for intravenous drug abuse:
 - (a.) Not later than 14 days after making the request *or*
 - (b.) Within 120 days of the request if the program has no capacity to admit the individual, the program makes interim services available within 48 hours, and the program offers the interim services until the individual is admitted to a substance abuse treatment program
3. Offer interim services, when appropriate, that include, at a minimum^[3], the following:
 - (a.) Counseling and education about HIV and tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur
 - (b.) Referral for HIV or TB treatment services, if necessary
 - (c.) Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women
4. Maintain a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.
5. Maintain a mechanism that enables the program to:
 - (a.) Maintain contact with individuals awaiting admission
 - (b.) Consult with the State's capacity management system to ensure that waiting list clients are admitted or transferred to an appropriate treatment program within a reasonable geographic area at the earliest possible time
6. Take clients awaiting treatment for intravenous substance abuse off the waiting list only when such persons:
 - (a.) Cannot be located for admission into treatment *or*
 - (b.) Refuse treatment
7. Carry out activities to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment by using scientifically sound outreach models such as those outlined below or, if no such models are applicable to the local situation, another approach which can reasonably be expected to be an effective outreach method:
 - (a.) The standard intervention model as described in *The NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual*, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, (Feb. 1992)

^[3] Interim services may also include federally approved interim methadone maintenance.

- (b.) The health education model as described in Rhodes, F., Humfleet, G.L. et al., *AIDS Intervention Program for Injection Drug Users: Intervention Manual*, (Feb. 1992)
- (c.) The indigenous leader model as described in Wiebel, W., Levin, L.B., *The Indigenous Leader Model: Intervention Manual*, (Feb. 1992)

8. Ensure that outreach efforts (have procedures for):

- (a.) Selecting, training, and supervising outreach workers
- (b.) Contacting, communicating, and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of Federal and State confidentiality requirements
- (c.) Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV
- (d.) Recommending steps that can be taken to ensure that HIV transmission does not occur

AMHI CONSENT DECREE

The Provider agrees to comply with the requirements of the AMHI Consent Decree by:

- (a) Having policies to assure class members of the AMHI Consent Decree are informed of their right to receive the services of a community support worker and other individualized support services; and
- (b) Providing written material explaining the client's rights as an AMHI Consent Decree class member to the services of a community worker and other individualized support services upon admission.

CO-OCCURRING DISORDERS

1. Co-occurring Disorders (MH/SA)

In support of the Department statewide initiative to create a system that is welcoming to patients with Co-occurring Mental Health and Addiction Disorders, the agency agrees to the following:

- (a.) The Provider shall not deny services to any person solely on the basis of the individual's having a known mental illness along with a known substance use/abuse disorder or because that individual takes prescribed psychoactive medications or participates in medication assisted treatment of their substance use.
- (b.) The Provider shall develop a written protocol or policy that describes its service approach to people with co-occurring mental illness and substance abuse or other co-occurring conditions.
- (c.) The Provider shall document the implementation of a training plan for staff in the interrelationship of mental illness and mood altering substances, the

identification of available co-occurring resources, and the referral and treatment process.

- (d.) The Provider shall institute a discrete screening process for identifying people with complex, co-occurring needs and diagnoses using a standard tool to be provided by the Department, currently the AC-OK.

2. Co-occurring Disorder Capability Development:

The goal of the Department is that all providers are required to be Co-occurring Capable. (COD-C) This expectation is reflected in DHHS policy and current SAMHS regulation. A COD capable program “is organized to welcome, identify, engage and serve individuals with co-occurring MH disorders and to incorporate attention to these issues in all aspects of program content and documentation. Such programs provide services that incorporate understanding of and approaches to mental health problems as they relate to and affect the substance abuse disorder. For more information, please refer to the Regulations for Licensing and Certifying of Substance Abuse Treatment Programs 14-118 CMR Chapter 5, Effective February 29, 2008, specifically sections 1.15-1.17.1, section 1.75, and section 5.1.

Providers are required to be fully COD capable by implementing the following:

- (a.) Providers will create and communicate a formal statement of intent to become COD capable to all staff.
- (b.) Providers will organize a formal Continuous Quality Improvement (CQI) process that addresses this goal.
- (c.) Providers will perform an organizational self-assessment of COD capability for each program using either the Maine Co-occurring Self-Assessment Tool or the COMPASS EZ.
- (d.) Providers will develop an action plan based on this self-assessment with measurable and achievable targets determined by the program.
- (e.) Providers will demonstrate that their CQI process tracks outcomes related to COD-C targets.
- (f.) Providers will demonstrate that their policies and procedures reflect attention to welcoming people with co-occurring diagnoses, improved screening, assessment, documentation, and treatment planning for people with COD, improved coordination of care for people with COD, and improved staff competency in providing services for people with COD.

SAMHS will provide assistance with and tracking of requirements in this Rider section at site visits of Block Grant contracted agencies. Requirement of a brief narrative related to COD-C status will be added to the year-end reporting requirement.

DRIVER EDUCATION AND EVALUATION PROGRAM (DEEP)

All contract agencies shall admit Driver Education and Evaluation Programs (DEEP) clients who meet their admissions criteria.

SUBSTANCE ABUSE SERVICES AT CORRECTIONAL FACILITIES

For Agreements with providers providing substance abuse treatment services at Maine Department of Corrections (DOC) correctional facilities:

The licensed Provider of the substance abuse services shall maintain custody of substance abuse treatment program records. Because the Provider shall be the custodian of the substance abuse treatment records, it shall also be the accountable party for ensuring that the confidentiality requirements of CFR42, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, are met. Closed substance abuse treatment program records may be stored at a correctional facility along with client medical and classification records. However, substance abuse records must have a cover sheet with a disclaimer stating that they are protected by CFR42. Only those persons who are authorized in accordance with CFR 42 shall have access to them. All closed substance abuse records must be maintained for a minimum of seven years. If a Provider discontinues operations, or is taken over or acquired by another Provider, disposition of patient identifying information and/or records shall be accomplished in accordance with CFR42.

LICENSE

Only substance abuse programs with a current license/certificate of approval are eligible to receive Office of Substance Abuse Treatment funding.

NON-DISCRIMINATION

Providers receiving grant funds from SAMHS will not discriminate against clients who are using legitimate medications to assist their recovery and will not have policies that allow them to refuse admission to treatment or to discharge clients from treatment based on the use of legitimate addiction medications.

Providers receiving grant funds from SAMHS will not discriminate against clients based on (third party) payor source. This is inclusive of Maine Care and Private Insurance. Providers will not have policies to refuse admission to treatment or to discharge clients from treatment based on their payor source.

BONDING

The Provider shall obtain and maintain at all times during the term of this Agreement a fidelity bond covering the activities of all employees who handle funds of the Provider in an amount equal to at least 20% of the total amount of this Agreement. This provision does not apply to Agreements that provide only MaineCare seed funds.

STAFFING

The Provider shall supply all staff training, clinical and administrative supervision, and evaluation appropriate to the performance of services under this Agreement. The Provider's staffing of all service programs contracted herein shall be in accordance with its final approved budget submission for the Agreement period.

OPIATE TREATMENT PROGRAMS

For Agreements with providers who conduct opiate replacement treatment, the Provider shall be required to utilize the Prescription Monitoring Program.

SMOKING CESSATION

All agencies providing Mental Health and/or Substance Abuse Services under this agreement shall have a current written tobacco policy addressing:

- (a.) Annual screening of individuals receiving MH/SA services for tobacco use and dependence
- (b.) Referral of individuals receiving MH/SA services to evidence-based tobacco cessation treatment
- (c.) Use of tobacco in agency facilities and on agency property. These policies shall comply with state law.

These policies shall be reviewed annually and updated as necessary. Updates shall be submitted to the DHHS program administrator upon update.

Resources regarding tobacco screening, treatment and policies may be found at <http://www.maine.gov/dhhs/mecdc/population-health/hmp/ptm/> and <http://www.project-integrate.org/tobaccofreepolicies.html>

TRAUMA INFORMED CARE

Trauma-Informed Care : The Provider shall have a plan for providing trauma-informed care based on principles of trauma-informed care and generally recognized bases of trauma-specific interventions, both as outlined by the Substance Abuse and Mental Health Services Administration at: <http://www.samhsa.gov/nctic/trauma-interventions>

LANGUAGE ACCESS

- A. Interpretation Services (Communication Access).** The Provider shall determine the primary language of individuals requesting services and ensure that the services are provided either by a bi-lingual clinician or with the assistance of a qualified interpreter when English is not the primary language. If not otherwise funded by MaineCare or some other source, the Provider shall obtain the service at its own expense. The client shall not be charged for this service.
- B. Accessibility for the Deaf and Hard of Hearing.** The Provider shall maintain and periodically test appropriate telecommunication equipment including TTY, videophone, or amplified telephone, or computer-based telecommunication programs, including IP-Relay services. Equipment or some form of access to relay services must be available and accessible for use by clients and staff for incoming and outgoing calls. The Provider shall ensure that appropriate staff has been trained in the use of the telecommunications devices and that if there is a TTY or video phone number, that the TTY telephone number is published on all of the Provider's stationery, letterhead, business cards, etc., in the

local telephone books, as well as in the statewide TTY directory. Where no TTY or VP number exists, providers should assure that clients are advised to use relay services by placing such information on providers stationary, letterhead, and business cards. The Provider, at its expense, shall obtain the services of a qualified sign language interpreter or other adaptive service or device when requested by a consumer or family member. Interpreters must be licensed with the Maine Department of Professional and Financial Regulation in the Office of Licensing and Registration. The Provider shall document the interpreter's name and license number in the file notes for each interpreted contact.

C. Deaf and/or Severely Hard of Hearing. Providers who serve deaf and/or severely hard of hearing consumers shall:

1. Provide visible or tactile alarms for safety and privacy (e.g., fire alarms, doorbell, door knock light);
2. Provide telecommunication access that is appropriate for the consumers' linguistic ability and preference and ensure the consumers have the relevant relay service, telephone numbers, or web sites readily available; and
3. Train staff in use and maintenance of all adaptive equipment in use in the program, including but not limited to hearing aids, assistive listening devices, videophone or TTY, fax machine, television caption controls, and alarms.

The Maine Center on Deafness <http://mcdmaine.org/> offers assistance to individuals who need specialized telecommunications devices who own their telephone. For consumers who rely on agency provided telephones, Maine Center on Deafness maintains telecommunication equipment to be the responsibility of the provider.

D. Provider Responsibilities: Deaf, Hard of Hearing and/or Nonverbal. Providers who serve deaf, hard of hearing, and/or nonverbal consumers for whom sign language has been determined to be as a viable means of communication shall:

1. Provide ongoing training in sign language and visual gestural communication to all staff on all shifts who need to communicate meaningfully with these clients, and shall document staff attendance and performance goals with respect to such training;
2. Develop clear written communication policies for the agency and each program of the agency, including staff sign/visual gestural proficiency expectations and when and how to provide qualified sign language interpretation; and
3. Ensure that staff and Provider case managers have a level of proficiency in sign language that is sufficient to communicate meaningfully with consumers OR
4. Hire an interpreter at all required check-ins at provider expense, if no signing case manager is available.

E. Contract Compliance

In addition to using the termination provisions contained in Rider B paragraph 15 and the set-off provisions contained in Rider B paragraph 26, the Department may exercise the following steps to ensure contract compliance:

Level 1: The Program Administrator will notify the Provider in writing of any contract compliance issues identified by Department staff. The notice will include the contract provision that is in noncompliance and a date by which the provider must comply.

Level 2: If the compliance issues described by the Program Administrator at Level 1 have not been addressed by the specified dates, the Provider and a representative or representatives of the Department's Office of Substance Abuse and Mental Health Services (SAMHS) will meet, discuss, and document the contract compliance issues. The SAMHS and the provider will develop a corrective action plan which must include:

1. A statement of the corrective actions required for compliance with the contract;
2. The date by which the Provider will comply with the terms of the contract;
3. The consequences for non-compliance; and
4. Signatures of the Provider and the SAMHS representative.

Level 3: If the Provider fails to undertake the corrective actions in the corrective action plan, the Department may terminate the contract in accordance with the procedures described in Rider B paragraph 15.

F. Consumer Satisfaction Survey.

The Provider shall support and participate in the annual Consumer Satisfaction Survey in accordance with the protocols developed by the Department.