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5510 Research Park Drive
P.O. Box 259038
Madison, WI 53725-9038
608.274.1820 | FAX 608.274.8554 | www.wha.org

May 17, 2019

Michael Derr
Department of Health Services
125 South Webster Street
Madison, WI 53707-7873

Comments submitted via email

RE: Comments on Proposed DHS 40. Clearinghouse Rule 19-018

Dear Mr. Derr:

The Department of Health Services invited stakeholders to comment on the Department's proposed repeal and recreation of DHS 40 pursuant to statement of scope SS085-15. The Wisconsin Hospital Association (WHA) appreciates that invitation.

WHA's membership includes over 140 member hospitals and integrated health systems. As integrated care providers that provide care to children with mental health needs in emergency, inpatient, and clinic settings, our members regularly see the impacts on access challenges for children with mental health needs. Relevant not only to our members that currently provide mental health day treatment services for children, a key priority for WHA and its membership is the reduction of regulatory burden governing behavioral health services because of that burden's impact on access behavioral health services.

WHA appreciates the significant amount of time across multiple Department Secretaries that the Department has worked on this rule. We also appreciate that the Department appears to have worked to consider and address technical concerns and has addressed some concerns raised by providers in the submitted proposed rule.

Unfortunately, while the Department has focused on addressing technical aspects of the rule language, WHA is concerned that the proposed update to DHS 40 fundamentally misses the mark. *Despite Wisconsin's well-documented need for additional access to mental health services for children, the proposed update to the Department continues a long tradition of overregulation of behavioral health services that creates barriers to entry to providers interested in providing these often scarce services.* Rather than looking to remove compliance complexity and fundamentally make it easier for providers and health care professionals to provide these services, the update to DHS 40 instead "modernizes" the existing DHS 40 terminology and details within its existing regulatory framework.

Particularly given the acute access challenges for children's mental health services, and consistent with WHA's October 2018 comments on the draft proposed rule, we believe that the Department should fundamentally and comprehensively reconsider, and even potentially repeal, the overly detailed and unnecessarily prescriptive DHS 40 regulation.

<u>DHS 40 creates unnecessary additional regulatory complexity in an already complex and highly regulated service area.</u>

As noted in the Department's Rule Summary, DHS 40 is not the only law governing the provision of youth mental health day treatment services in Wisconsin. In the Rule Summary, the Department provides a lengthy list of state and federal

statutes and rules that together constitute *hundreds of pages of regulations* governing child day treatment:

- Sections 51.14, 51.30, 51.61, Stats.
- Chapters 48, 51, 54, Stats.
- Chapters DHS 12, 13, 92.
- Sections DHS 106.06 and 106.28 (1)
- Chapters MPSW 4, 12, 16
- Chapter Psy 2
- Sections RL 160.02 (6) and 160.02 (7)
- Sections N 8.02 (1) and N 8.06
- Section Med 8.08
- Chapters SPS 361 to 365
- 45 CFR Parts 160, 162 and 164

Although this is a lengthy list of mental health requirements, children's code requirements, guardianship requirements, community program services requirements, background and misconduct requirements, professional licensure requirements, and confidentiality requirements, this list actually misses other significant laws, governing bodies and standards that apply to the provision of youth mental health day treatment services. For example, hospital regulations, professional credentialing, public and private payment rules, false claims laws, private accreditation standards (both facility and professional), and liability/negligence laws all also apply to such services.

Without DHS 40 – either in its existing or proposed form - the provision of youth mental health day treatment services is hardly devoid of standards and oversight to ensure the public's protection. We question whether layering DHS 40's additional compliance obligations on youth day treatment providers onto an already highly regulated and scrutinized area of health care creates a marginal benefit to Wisconsin that outweighs the direct costs and compliance costs the rule has on existing and potential providers of scarce youth mental health services.

Wisconsin's DHS 40 is an outlier compared to other states.

One long established part of Wisconsin's rulemaking process has been to include in the Rule Summary a "Comparison with rules in adjacent states," as a tool to help assess the reasonableness of the proposed rule.

In the Rule Summary, the Department cites to specific rule provisions for Illinois, Michigan, and Minnesota, and a provider manual for Iowa that regulate youth day treatment. However, a closer analysis of each of these state cites reveals that only Iowa directly regulates youth mental health day treatment services, but only as a condition of Medicaid payment and in a significantly less proscriptive and detailed way compared to DHS 40.

> *Illinois.* The Rule Summary indicates that "Illinois' youth day treatment programs are regulated through the Illinois State Board of Education (ISBE) in 23 Ill. Adm Code 401 Subpart A." However, that regulation – administered by the State Board of Education – only governs "special education programs" for "students." A WHA member that provides youth mental day treatment services in Illinois confirmed that Illinois has no similar provision to DHS 40 that certifies and directly regulates such services.
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> *Iowa.* The Rule Summary indicates that "Iowa's youth day treatment program is not currently regulated by rule. Iowa's Department of Human Services instead provides Psychiatric Medical Institutions for Children (PMIC) Provider Manual." The referred to provider manual is the state's Medicaid provider manual describing coverage requirements and conditions of payment, not a licensure/certification requirement. Further, the Iowa Manual is significantly less detailed and proscriptive. As one illustration, its word count is 2675 words addressing child mental health day treatment services compared to current DHS 40's 11,548 words and proposed DHS 40's 13,205.

Michigan. The Rule Summary indicates that "Michigan's youth day treatment programs are regulated by the Michigan Department of Health and Human Services in Mich. Admin Code R 330." However, R330 is a citation to a chapter governing mental health generally in Michigan. While R 330 has general mental health provisions applicable to the provision of mental health day treatment, Michigan does not appear to have separate certification/licensure for mental health day treatment in R330.

Minnesota. The Rule Summary indicates that "Minnesota's youth day treatment programs are regulated by the Minnesota Department of Human Services in Minn. R. 9505.0370, 9505.0371, 9505.3072." However, these citations are citations to mental health coverage requirements for the Minnesota Medicaid program. A review of those Medicaid citations reveals special treatment for *adult* day mental health day treatment, but does not specifically address child day mental health day treatment. However, even using the Minnesota adult day treatment provisions as a comparison, those provisions are significantly less detailed and proscriptive than DHS 40. As one illustration, Minnesota's Medicaid regulation regarding adult day treatment is only 730 words, and the entirety of the Minnesota Medicaid regulations pointed to in the Rule summary is 7469 words. In comparison, current DHS 40 has 11,548 words and proposed DHS 40 has 13,205.

Other states. Based on feedback received from a provider that provides child day treatment services in multiple other states, only half have a license requirement, and of those, Wisconsin's DHS regulates at a much more detailed and granular level.

A close review of other state laws highlighted in the Rule Summary shows that not only is Wisconsin's facility licensure approach to child mental health day treatment services an outlier, but its specificity and impact on granular care delivery is an outlier as well. Based on these other states' regulatory approach, we do not agree with the Rule Summary's statement that "There are no reasonable alternatives to the proposed rule changes," and based on the review of other states, the Department should consider fully repealing or drastically simplifying DHS 40.

DHS 40 expresses "best practice" standards rather than minimum, critical standards that are fundamental to the protection of the public.

The Rule Summary's Plain Language Analysis section states "Chapter DHS 40 has not been revised since 1996 and no longer reflects current terminology or *best* practices in mental health day treatment, treatment planning, and diagnostics." As written, DHS 40 frequently reads like a *best* practice or ideal scenario rather than a set of critical standards fundamental to the protection of the public.

We are concerned that by establishing "best practices" rather than minimal standards, the regulations don't take into account the diversity of Wisconsin's community needs and available resources, and could result in "no practice" if the aspirational standard cannot be met. For example, while it may be preferable to have a child psychiatrist or a general psychiatrist with multiple years of clinical experience working with youth, does the public need to be protected from having a general psychiatrist from providing mental health day treatment services at any time? Is there a greater risk in a youth not having timely and local access to day treatment services than having a child receive services from a general psychiatrist?

While aspirational, "best practices" need to be weighed against other local and temporal realities and needs. Fundamentally, DHS 40 should be revisited with the following question in mind: Should Wisconsin use the force of law to stop an organization from providing child mental health day treatment services in a community for failing to meet a "best practice" or only when a practice so deviates from acceptable norms that action must be taken to protect the public?

DHS 40's Economic Impact Analysis does not fully capture the administrative or opportunity costs of the rule.

In October 2018, WHA submitted a comment letter on DHS 40 as part of the Economic Impact Analyses process, inviting the Department to consider the full compliance and opportunity costs of the rule. Our concerns expressed then continue:

> "Regulatory prescriptiveness and the compliance burden of "showing your work" for regulatory requirements creates additional administrative costs to operate a program, adds to paperwork burden for clinicians that either reduces the number of patients the clinician can see or increases the clinician's overall workday, and limits innovation and flexibility among providers to provide efficient, high quality care. These costs are difficult to fully quantify, but together with professional requirements and regulations, payer requirements, liability risk mitigation and other overlapping regulatory requirements and processes that also assure minimum levels of quality and safety, add up to not insignificant administrative and opportunity costs for health care providers. We believe that the rule could be improved by reducing the regulatory burden and overall cost of DHS 40, not simply maintaining or limiting the economic impact of the update to DHS 40 compared to the current rule."

Additionally, as noted in the Fiscal Estimate & Economic Impact Analysis, Rogers Behavioral Health expressed significant concerns about the costs of the rule. While the Department's Economic Impact Analysis indicates an estimated $33,364 implementation and compliance cost to businesses, local government and individuals, Rogers Behavioral Health maintains that the proposed rule will increase *just* Rogers' costs by up to $2.3m and an additional 33FTE to comply with the rule.

Given the significant discrepancy on the estimated economic impact on providers of these child mental health services, WHA urges the Department to work with Rogers to ensure that there is a full and accurate understanding of this costs of this proposed rule.

DHS 40 may lack statutory authority to regulate all youth mental health day treatment facilities.

Both the Statement of Scope and the Rule Summary point to a single statute for statutory authority for DHS 40: Section 51.42(7)(b). Section 51.42, titled "Community mental health, developmental disabilities, alcoholism and drug abuse services," is typically identified as a statute defining the governance and duties of *county community programs*. However, the proposed DHS 40 rule attempts to regulate not only *community* youth day treatment services and facilities governed by county community programs boards and directors, but *all* youth day treatment services and facilities.

Except for Chapter DHS 34, it appears that no other DHS rule that certifies or licenses behavioral health facilities or services relies solely on Section 51.42 as its promulgation authority. However, unlike proposed DHS 40, DHS 34 makes clear that DHS 34 only applies to county provided or county contracted services:

> **"(2)** This chapter applies to the department, to counties that request certification or are certified to provide emergency mental health services and to county-contracted agencies that request certification or are certified to provide emergency mental health services.
> **(3)** This chapter relates only to the certification of programs providing emergency mental health services. It is not intended to regulate other mental health service programs or other emergency service programs." Chapter DHS 34.01.

This treatment of DHS 34 is consistent with the read of the word "community" in section 51.42 to refer to county-based or county-contracted mental health services, not all mental health services. Consequently, it is not clear that the statutory authority pointed to in the Statement of Scope or Rule Summary supports the application of DHS 40 to facilities that are not governed by a county community programs board, director, or contract.

There is a critical need for behavioral health services in Wisconsin, yet behavioral health service providers face one of the most complex web of laws, regulations, and payment policies of any health care service area. Many of these laws are a legacy of long past policy, practice, and perceptions that marginalized and siloed behavioral health care. Unfortunately, much of that regulatory legacy created to protect individuals with mental illness during a different era now harms individuals in the present through access bottlenecks caused by regulatory costs and inflexibility.

Just as WHA championed HIPAA Harmonization reforms that have resulted improved care coordination for individuals with mental illness by removing outdated mental health records laws, WHA will continue to advocate for policies to

improve access to behavioral health services by removing outdated and unnecessary behavioral health regulations such as those in DHS 40.

Sincerely,

Matthew Stanford
General Counsel
Wisconsin Hospital Association, Inc.
mstanford@wha.org