3176 14-538-30

Champa, Heidi

From:	Justin Fleming <justin@papsy.org>
Sent:	Monday, September 11, 2017 3:42 PM
To:	PW, OPCRegs; irrc@irrc.state.pa.us
Cc:	stefiorill@pa.gov; Rush, Jean
Subject:	IRRC Regulation #3176 Public Comment from the Pennsylvania Psychological Association
Attachments:	IRRC Regulation 3176 Public Comments.pdf

Dear Ms. Rosenberger,
Please see the attached public comment from the Pennsylvania Psychological Association on the proposed rulemaking related to outpatient behavioral health services and psychiatric outpatient clinics (Regulation #14-538, IRRC #3176). Thank you for the opportunity to provide comments. We look forward to being a part of this process moving forward.

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September 11, 2017

Ms. Michelle Rosenberger
Office of Mental Health and Substance Abuse Programs
Bureau of Policy Planning, and Program Development
Commonwealth Towers, 11th Floor, 303 Walnut Street
PO Box 2675
Harrisburg, PA 17105-2675

Dear Ms. Rosenberger:

On behalf of the Pennsylvania Psychological Association, I am writing to express some concerns regarding the proposed regulations for Outpatient Psychiatric Services and Psychiatric Outpatient Clinics (Regulation #14-538, IRRC #3176) which were published on August 12, 2017 in the *Pennsylvania Bulletin*.

We note many positive changes in these regulations. The time frame for the development of treatment plans is increased from 15 to 30 days; the frequency of treatment plan updates is increased from 120 days (or 15 visits) to 180 days; and the length of time for psychiatric reviews of treatment plans is increased from 120 days to 1 year. The proposed regulations also allow for telepsychiatric services and increase the use of advanced practice nurses and physician assistants.

However, we note that these proposed regulations, although moving Pennsylvania in the right direction, fail to make sufficient changes to address the many needs of patients. Nowhere is this clearer than in their failure to address the needs of clinics offering integrated care. Integrated care occurs when entities offer medical and behavioral health services within one setting. A recent editorial in the *Journal of the American Medical Association* stated that team-based or integrated care was "clearly superior" to traditional care "for patients with complex mental illness and chronic medical disease" (Schwenk, 2016, p. 822). The Centers for Medicare and Medicaid Services (CMS) is promoting integrated care through demonstration grants and offers of technical assistance. Many commercial insurers in Pennsylvania and nationwide are promoting an integrated approach to health care delivery.

These regulations still contain numerous provisions that impede the movement toward integrated care. For example, the regulations require extensive documentation including social and psychological histories, a detailed treatment plan, and a discharge summary. These are not always needed for patients in integrated care facilities who often receive short-term services typically linked closely to their medical illnesses. Patients in integrated care settings often have behavioral interventions as one component of their total care. They retain their original physical health diagnosis and continue under the treatment of the primary care or specialty physician even after they have completed behavioral health services. Thus, any discharge summary is

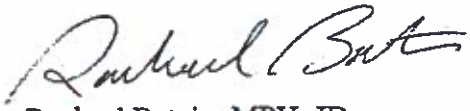
misleading because the patients are not discharged from the treatment for their medical problems.

These facilities have, under the new regulations, 30 days from the first patient visits to develop treatment plans and 180 days until the next treatment update. However, most patients receiving behavioral health services in an integrated care setting complete their services within 180 days (many within 30 days). Furthermore, some patients do not even have a mental health diagnosis and are receiving psychoeducational services or services that use Health and Behavior Codes, designed for behavioral interventions for physical disorders.

Finally, the requirements for psychiatric supervision are especially problematic in integrated care settings where non-psychiatric physicians or psychologists typically manage the treatment. Psychologists are independently licensed doctoral level professionals who can provide behavioral health services without needing supervision from a physician. It is a barrier to access to care for patients to need to find mental health providers who have a psychiatrist supervising them. There is a chronic shortage of psychiatrists that is not expected to improve, and expecting all care to require oversight by a psychiatrist is not in the best interest of serving the public. Furthermore, requiring a psychiatrist's involvement increases healthcare costs unnecessarily.

In conclusion, we are grateful for your willingness to make substantive change within the current behavioral health system, but note that many more changes are needed to bring current regulations in line with acceptable professional standards of practice.

Sincerely,



Rachael Batuin, MPH, JD
Director of Legal & Regulatory Affairs
PA Psychological Association

References

Schwenk, T. (2016). Integrated behavioral and primary care: What is the real cost? *Journal of the American Medical Association, 316*, 822-823.