



## Arizona Hospital and Healthcare Association

January 16, 2009

Kathleen Phillips, Esq.  
Rules Administrator and Administrative Counsel  
Arizona Department of Health Services  
1740 West Adams, Suite 202  
Phoenix, Arizona 85007

Re: OBHL Rulemaking

Dear Ms. Phillips:

We understand that the Arizona Department of Health Services (ADHS) is in the process of reviewing and updating the Office of Behavioral Health Licensure (OBHL) regulations. We are pleased that ADHS has undertaken this rulemaking project. As you know, many Arizona Hospital and Healthcare Association (AzHHA) members are directly impacted by the OBHL regulations, and we have been concerned with the regulations for many years. Accordingly, we have convened a task force to review and comment on the current OBHL regulations. We would like to provide you with some initial comments for ADHS' review and consideration during the rulemaking process.

As we reviewed the rules with our members, two significant overriding concerns came to light. First, the number of inconsistencies between the OBHL regulations and regulations that hospitals must follow under federal Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) and state Office of Medical Facilities Licensure (OMFL) became very apparent. Second, the OBHL regulations themselves consist of a myriad of interwoven internal references, which are extremely difficult to follow. This lack of transparency coupled with the inconsistencies between OBHL and federal CoPs/state OMFL regulations make navigating the behavioral health regulatory system extremely difficult. With this in mind, we are recommending a more streamlined regulatory framework for hospitals providing behavioral health services – one which provides greater efficiency and transparency without jeopardizing patient safety and effective care.

As an initial matter, we strongly urge ADHS to eliminate the dual licensure system for hospitals operating behavioral health units. A more detailed explanation of this recommendation is provided below. Second, urge ADHS to restructure and reorganize the OBHL rules in a manner more reflective of OMFL regulations. We believe such a change would eliminate duplicative and sometimes inconsistent provisions and make the rules themselves more transparent. A more detailed explanation of this recommendation is provided below. Finally, we have completed our review of A.A.C. R9-20-101, and we

enclose our comments to this regulation for your review and consideration. We will continue to provide you with our comments to additional OBHL regulations as the task force completes its work.

I. ADHS should utilize a single licensing system for hospitals that provide behavioral health services.

Arizona hospitals that provide behavioral health services are required to obtain two separate ADHS licenses – one from the OMFL and one from OBHL. This dual licensing system differs from the general ADHS licensing regulations, which specifically avoid dual licensure by exempting a behavioral health agency licensed by OBHL from having to obtain an additional license from OMFL. See A.A.C. R9-10-103(A). Instead, Arizona’s hospitals are treated differently from all other types of health care institutions and behavioral health service agencies in the state in that they are required to obtain both an OMFL license and an OBHL license. See A.A.C. R9-10-224 and A.A.C. Title 9, Chapter 20.

We believe this dual licensing system is unnecessary, creates undue burden for hospitals, and is inefficient and more costly for ADHS. The dual licensing system is unnecessary because hospitals, including hospital behavioral health units, are already licensed and surveyed for compliance with state laws by OMFL. OMFL currently regulates the provision of all other types of hospital services, including pediatric, intensive care, surgery, radiology, emergency, and laboratory services. We do not see any reason why behavioral health services should be treated any differently from these other service lines. Indeed, we are not aware of any patient safety or patient outcome data that would justify this added level of scrutiny.

The dual licensing system creates undue burden for hospitals because of separate and often conflicting licensing processes, interpretations, and enforcement. By way of example, the OBHL license application is duplicative of the information that must be provided to OMFL for its licensing purposes, yet both divisions require that the information be submitted separately to each division. The effective and expiration dates for both licenses rarely coincide, which has proven problematic for hospitals, and the OMFL and OBHL definitions and regulations are often in direct conflict, which makes it extremely difficult for hospitals to comply with both sets of requirements. For example, OMFL and OBHL have two different and conflicting definitions of when a patient is an “adult,” what constitutes an “admission” or “discharge” from the facility, and what constitutes a patient assessment. The enclosed AzHHA comments to A.A.C. R9-20-101 identify these, and other, conflicts and inconsistencies. In addition, hospitals are subject to two separate enforcement processes and enforcement may be based on the same conduct identified and enforced by the other ADHS division, resulting in duplicative fines and appeal processes.

Finally, the dual licensing system is inefficient and more costly for ADHS. As a result of this system, ADHS must utilize two separate administrative and survey teams to process the two sets of hospital licenses and confirm hospital compliance. This results in duplicative work and is therefore inefficient and more costly for ADHS. At a time when government spending is a concern, eliminating this duplicative system would be an excellent way to reduce ADHS costs.

We therefore request that the Department treat hospitals as it does all other facilities by requiring that hospitals obtain only one ADHS license. Specifically, we ask that the OBHL rules exempt hospitals licensed by OMFL from OBHL licensure, like A.A.C. R9-10-103(A) exempts OBHL licensed facilities from OMFL licensing. Additionally, we ask that the OMFL rules be amended to set forth the additional requirements for hospitals that provide behavioral health services. This change would parallel the framework of the federal CoPs, and create a more uniform, streamlined regulatory structure.

II. ADHS hospital regulations should be outcome-oriented and have the flexibility and transparency necessary for the provision of safe and efficient behavioral health care services.

Hospitals are subject to state, federal, and accreditation requirements, therefore the OMFL rules regarding specific hospital services are drafted in a manner that addresses expected outcomes related to patient care and does not micromanage day-to-day hospital services (see *e.g.*, A.A.C. R9-10-225, OMFL requirements for rehabilitation services). This broad regulatory system prevents OMFL regulations from becoming quickly outdated and conflicting with federal laws, such as CMS' CoPs. In addition, it provides hospitals with the flexibility necessary to provide safe and efficient health care services.

The OBHL rules, in contrast, dictate behavioral health requirements in very specific detail, which then become quickly outdated. While this detail might be useful in the regulation of smaller behavioral health agencies, it is unnecessary and problematic in the hospital context because it inevitably results in discrepancies and inconsistencies with other regulations to which hospitals are subject. This problem is not easily remedied.<sup>1</sup> In addition, OBHL's micromanagement of hospital operations has, in some cases, hindered hospitals' ability to provide behavioral health care services. The current regulations, for example, contain very specific criteria for personnel in order to be qualified to provide behavioral health services. OBHL's definitions are so restrictive that many ED physicians with extensive behavioral health experience are not deemed qualified to provide behavioral health services. These restrictive requirements adversely affect

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<sup>1</sup> By way of example, A.A.C. R9-20-602(D)(1), an OBHL rule regarding face-to-face assessments within one hour after the initiation of restraint or seclusion, is in direct conflict with the CoPs. While this OBHL rule might have been consistent with the CoPs when it was first written, it has directly conflicted with the CoPs since December 8, 2006. It took ADHS almost two years to address this conflict in a Guidance Document, which permitted hospitals to follow the CoPs, rather than the OBHL rule, and it will likely be several more years before the regulation is finally amended to reflect this important change.

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hospitals' ability to obtain sufficient health care personnel to provide behavioral health care services, particularly given the current shortage of health care professionals.

To remedy these concerns, we recommend that OBHL follow the OMFL model and require hospitals to have and implement policies and procedures designed to achieve OBHL's desired result and to monitor the effectiveness of these policies and procedures through the hospital's quality improvement program. For example, OBHL should require hospitals to have policies and procedures that set forth the required competencies and training for specific behavioral health personnel and to monitor the effectiveness of these competencies and qualifications, rather than setting forth a laundry list of detailed qualifications for each type of behavioral health care provider. We believe that broader, more flexible, goal-oriented regulations will improve the longevity of the new regulations and hospitals' ability to provide safe and efficient behavioral health care services.

Finally, we believe that the current regulations lack the transparency necessary for hospitals and other types of behavioral health care facilities to fully understand and comply with their regulatory requirements. The regulations are poorly organized, contain too many cross-references, and are often subject to different interpretations. We will provide examples for your review in future comments, but in the interim, request that ADHS be mindful of this concern.

Thank you for your consideration of AzHHA's initial comments to the existing OBHL regulations. We look forward to working with you throughout this rulemaking process and participating in any future stakeholder meetings or discussions. If you have any questions about our comments to date, please feel free to contact me at 602-445-4300 or [djohnston@azhha.org](mailto:djohnston@azhha.org).

Sincerely,



Debbie Johnston  
Director of Regulatory Affairs and Policy

Enclosure