National Association for Behavioral Healthcare

Access. Care. Recovery.

2 June 2020

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Regulatory Relief to Support Access to Behavioral Healthcare

Dear Ms. Verma:

On behalf of the National Association for Behavioral Healthcare (NABH), thank you for the regulatory relief the Centers for Medicare and Medicaid Services (CMS) has provided during the Covid-19 pandemic. Our members appreciate these adjustments.

I am also writing to ask you to consider streamlining other requirements, including the additional Conditions of Participation specific to psychiatric facilities. NABH represents healthcare provider systems that include psychiatric hospitals as well as other settings focused on providing mental health and addiction treatment. The need for regulatory relief is even more critical for our members during the current public health emergency, as they are working around the clock to provide safe, effective care to patients with mental health and substance use disorders.

Recent polls have found that Americans are experiencing increasing levels of psychological distress.[i] Moreover, past epidemics have shown that the impact on behavioral health will continue for years to come.[ii] Reports of exponential increases in calls to mental health crisis hotlines at the federal level and in major cities are indications of this looming behavioral health crisis.[iii] Economic downturns, such as the one America is experiencing now, are associated with higher rates of suicide,[iv] and we were already grappling with increasing suicide rates[v] and the on-going opioid/addiction crisis before Covid-19 arose. This pandemic has further magnified the need for improved access to behavioral healthcare. Unfortunately, we know there are severe shortages of behavioral healthcare providers, including inpatient psychiatric treatment facilities, in many parts of the United States. It is critical that we lessen the administrative burden on behavioral healthcare providers so they can devote more of their staff time and resources to providing care instead of filling out paperwork.

Many psychiatric hospitals have negative net operating margins despite offering services that are in high demand in communities across the country. The burden of the additional regulatory requirements these settings must meet to participate as Medicare providers is a significant factor affecting the financial health of these valued healthcare organizations.

The additional Conditions of Participations (CoP) for psychiatric hospitals and accompanying sub-regulatory guidance in the State Operations Manual (known as the B-tags) impose more than $625 million in additional costs annually, according to a recent study.[vi] The Covid-19 pandemic has added to the strain on these facilities with additional financial losses and unexpected costs, including those related to greatly increased personal protective equipment, screening everyone coming into the facility, additional staffing needs for screening, and other infection control measures, including isolation rooms and units, software and hardware purchases to facilitate telework for administrative staff and telehealth for patients, and lost revenue due to decreased patient volume because of infection concerns and reduced referrals.

In accordance with President Trump's May 19 Executive Order on "Regulatory Relief to Support Economic Recovery,"[vii] we recommend the following actions:

1. **Eliminate the additional CoPs for psychiatric hospitals**: The topics addressed in these additional

psychiatric CoPs are outdated, overly burdensome, or already adequately addressed in the broader CoPs that all hospitals, including psychiatric hospitals, must meet.

2. **Continue critical CoP flexibilities established during the Covid-19 pandemic:** We request that CMS continue flexibility regarding some of the CoP for general hospitals that were waived during the Covid-19 pandemic. These flexibilities have enabled psychiatric hospitals to increase efficiency while maintaining access to acute inpatient care for those with the most serious behavioral health conditions.

3. **Maintain enhanced coverage of telehealth for behavioral healthcare**: We urge that CMS continue to provide expanded Medicare coverage of telehealth as this has been critical to preserving access to care during Covid-19, and an increased need for behavioral healthcare will continue for years after the pandemic has ended.

1. Eliminate Additional Conditions of Participation for Psychiatric Hospitals

Inpatient psychiatric facilities must satisfy the CoP that apply to all general hospitals, as well as additional CoP that address psychiatric patient evaluations, medical records, and staffing.[viii] CMS has issued 60 pages of sub-regulatory guidance regarding the additional psychiatric hospital CoP, in which the agency specifies multiple distinct compliance elements for each regulation referred to as B-tags. CMS issued the CoP in 1966 and the sub-regulatory guidance in the 1980s. The recent Supreme Court decision in *Azar v. Allina Health Services* on the agency's use of sub-regulatory guidance to establish detailed binding requirements also points to the need to review and consider eliminating the sub-regulatory B-tags.

When these rules were issued, many psychiatric patients remained hospitalized for months or even years, and occasionally languished with only minimal medical or clinical attention. Today, the average length of stay at an inpatient psychiatric facility is measured in days, not months. Multidisciplinary teams of clinicians communicate frequently with patients and with each other. Often, the care team's goal is to stabilize patients so they can return safely to the community as soon as possible and continue treatment in an outpatient setting. Clinicians must now gather the same amount of documentation in days that they once had weeks or months to produce on criteria that are outdated. Furthermore, many surveyors strictly apply these criteria requiring costly and unnecessary alterations in procedures, equipment, and facilities as well as low-value documentation.

Documentation in the Patient's Medical Record – 42 CFR §482.61

Every hospital—psychiatric or general acute— is required to maintain a comprehensive medical record for each patient. For inpatient psychiatric facilities, the sub-regulatory B-tags specify numerous requirements that psychiatric hospitals must meet in precise ways with a level of detail and frequency that is no longer appropriate. Moreover, the general CoP that apply to all hospitals incorporate many very similar requirements for medical records including inclusion of examination results, medical history, admitting diagnosis, treatment provided, and nursing notes, as well as discharge planning including plans for follow-up care. Therefore, this additional set of burdensome regulations for psychiatric hospitals is unnecessary as well as costly.

For example, the regulation at 42 CFR §482.61(c)(1)(ii) specifies that a treatment plan should list patients' short- and long-term goals [see B118-125]. Requiring psychiatric treatment planning aligned with very detailed short and long-term goals written in behavioral language for hospital stays of 5 to 10 days is wasteful of scarce clinical resources. Treatment planning can be much more efficiently practiced if tailored to the needs of the patient. Moreover although the interpretive guidance [B121] expressly states that in a "short-term treatment" scenario, "there may be only one timeframe for treatment goals", many surveyors expect to see multiple short- and long-term goals, irrespective of the patient's expected length of stay. As a result of this expectation, clinicians are spending too much time filling out paperwork to demonstrate compliance instead of focusing on patients. Demonstrating compliance is not equivalent to quality patient care.

Another example of overly burdensome regulation is the implementation of 42 CFR §482.61(b) to require that the psychiatric evaluation be completed or overseen by a physician [see B110]. This limitation prevents qualified staff such as Advanced Practice Registered Nurses (APRN) from practicing to the full extent of their licensure and qualifications. Allowing APRNs to practice to the full extent of their license would help alleviate some of the barriers to care created by the national shortage of psychiatrists.

The requirement in §482.61(c)(2) that the treatment plan include documentation of all active therapeutic efforts is also unnecessary and outdated. While active treatment remains an essential aspect of psychiatric care services, the requirements as outlined in B125 do not reflect current, standard treatment and instead relate to past modalities when patients were cared for in larger, long-term settings. Because acute hospitalizations are now much shorter than they were previously, a focus on crisis stabilization with safe discharge to lower levels of care reflects current active treatment more accurately.

Surveyors of psychiatric hospitals often reject use of stock language in the treatment plan, even if a care pathway defines clinician roles that do not meaningfully vary from patient to patient (e.g., psychiatrists prescribe medications, nurses administer medications, social workers assist with discharge planning). Clinicians therefore must spend time crafting highly tailored, free-text plans and progress notes. Often, these documents must be written by hand because many freestanding psychiatric hospitals do not have electronic health records (partly, because they were excluded from the federal support for health information technology implementation provided in the *Health Information Technology for Economic Clinical Health (HITECH) Act* (Pub.L.111-5). This approach is out of step not only with standard practice in non-psychiatric disciplines, but also with the medical industry's trend toward appropriate use of check boxes and standardized language, which saves clinicians time and, when contained in an electronic record, makes the data more searchable, analyzable, and portable.

Additional outdated, overly burdensome, or unnecessary requirements for medical records:

- Requirements for the psychiatric evaluation, §482.61(b) and B110-B117. These requirements go well beyond what is medically necessary and what any other medical specialty is required to document. All other specialties are held to requirements under evaluation and management initial evaluation codes (e.g. 99221-99223). The same standard should apply to psychiatric hospitals.

- Requirement that the treatment plan include specific modalities, §482.61(c)(1)(iii) and B122. This regulation has been interpreted to require that each discipline specify the purpose and focus of each treatment modality. The purpose seems implicit in the modality, and the goal would be the stated goal for all modalities, making this requirement redundant and unnecessary.

- Requirement that the treatment plan include the responsibilities of each member of the treatment team, §482.61(c)(1)(iv) and B123. This additional documentation is unnecessary because team members are identified elsewhere in the medical record.

- Progress notes requirements, §482.61(d) and B130-B132. The frequency of progress notes and the requirement to tie each to a precise treatment plan goal are antiquated requirements without practical value. No other provider specialists are held to this standard. Naming all the staff involved in each problem/intervention is redundant since the staff sign the treatment plan. One daily entry per discipline inclusive of all services provided would be sufficient and reduce time spent on documentation.

Qualifications for Certain Director-Level Administrative Staff – 42 CFR §482.62

The staffing requirements for psychiatric hospitals are much more detailed than requirements that apply to any other specialty providers and require psychiatric facilities to appoint various director-level positions. We focus here on the requirements for a director of nursing who must be either: 1) "a registered nurse who has a master's degree

in psychiatric or mental health nursing" or an equivalent degree from an accredited nursing school, or 2) a person who is otherwise "qualified by education and experience in the care of the mentally ill", 42 CFR 482.62(d)(1) and B146. Even though CMS regulations allow for a nursing director who is "qualified by education and experience," some agency surveyors reveal a clear preference for specific academic credentials. In one recent example, a surveyor questioned the qualifications of a director who had a Master of Science degree in nurse administration and more than three decades of work experience in psychiatric settings, plus certifications and continuing education coursework germane to psychiatric care.

This approach contradicts present-day practice in two ways. First, candidates with a master's degree in psychiatric nursing are in short supply. Many individuals who possess such a degree become advanced practice clinicians, rather than hospital nursing directors. Second, advanced practice nurses may gain years of experience working in psychiatric facilities even if they do not have a degree in psychiatric nursing. Moreover, a registered nurse with psychiatric experience can make an excellent director of nursing, especially if the nurse holds a bachelor's degree in a relevant subject such as hospital management. Additionally, this specific requirement does not exist in any other hospital type CoP.

2. Continue Critical CoP Flexibilities Established During Covid-19 Pandemic

We also request that CMS continue to provide flexibility regarding the following general CoP after the emergency declaration has expired. Many of these requirements and restrictions prevent psychiatric facilities from being able to fully use their staff to offer care because of unnecessary administrative requirements that take them away from their patients or limit the ability of staff to provide care that they are qualified and otherwise authorized to provide.

- **Care of patients,** 42 CFR §482.12(c)(1), (2), and (4). The flexibility regarding these regulations during the pandemic has allowed hospitals to employ nurse practitioners and other mid-level providers to the fullest extent of their licensure and scope of practice in the state where they practice. This change has greatly expanded the capacity of staff to provide behavioral healthcare. Continuing this policy is particularly important because there are such significant shortages of behavioral healthcare providers in many parts of the country, and we expect these shortages to increase in the coming months and years. Almost 120 million people currently live in mental health professional shortage areas.[ix] About half of U.S. counties and 80% of rural counties have no practicing psychiatrists, and over 60 percent of psychiatrists are nearing retirement.[x]

- **Nursing care plan requirements**, 42 CFR §482.23(b)(4). The specifications for these plans are overly burdensome and should be streamlined.

- **Authentication of verbal orders**, 42 CFR §482.23(c)(i-iii). The additional flexibility allowed during the pandemic should be maintained where read-back verification is required, but authentication may occur later than 48 hours.

- **Food and Dietetic Services**, 42 CFR §482.28**.** The provision that requires providers to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel is unnecessary.

- **Utilization Review**, 42 CFR §482.30. This section includes a long list of specific requirements for a utilization review committee, the scope and frequency of reviews, determinations regarding admissions or continued stays, and extended stay review. These specifications are overly prescriptive and unlikely to result in quality assurance.

- **Discharge planning requirement to provide a list of post care facilities, financial disclosure, quality data, and information on managed care requirements**, 42 CFR §482.43(a)(8) and 482.43(c)(1-3). The

types of post-acute care settings that must be incorporated into discharge planning under these regulations are not focused on addressing mental health conditions or addiction. Moreover, obtaining the required data on these other settings is burdensome. Furthermore, it is counterproductive to provide information on treatment settings which do not address the needs of the patient or to which a patient may not be accepted or have the means to access.

3. Maintain Enhanced Coverage of Telehealth for Behavioral Healthcare

We urge CMS to continue Medicare coverage of mental health and addiction treatment services delivered via telehealth as currently allowed under section 1135 waiver authority. The ability to provide care via telehealth technologies creates tremendous opportunities to improve access to care which we know will be in ever increasing demand following this pandemic. Our members have been able to continue many of their usual programs and have seen some increases in attendance due to the ease of access that telehealth allows. Telehealth has been shown to be particularly effective in delivery of some forms of behavioral healthcare.[xi] We urge that Medicare continue the following policies regarding coverage of behavioral healthcare services via telehealth:

- Cover services provided to patients in their homes without requiring them to travel to an originating site facility or be located in a rural or professional shortage area;
- Allow telehealth services to be provided to new and established patients;
- Maintain the expanded list of behavioral healthcare services that can be covered when provided via telehealth;
- Continue to allow behavioral health clinicians to determine which patients could benefit from receiving services via telehealth and which services can be effectively delivered via telehealth;
- Continue allowing use of widely available audio-visual software, such as FaceTime and Skype, for behavioral healthcare via telehealth;
- Continue covering care provided via telehealth across state lines as long as the provider is properly licensed in their home state;
    - And to facilitate implementation of this flexibility within the Medicare program, provide up-to-date information on the CMS website regarding which states are continuing to allow out-of-state providers to provide services via telehealth;
- Continue covering evaluation and management and behavioral health counseling as well as opioid/addiction treatment program counseling and periodic assessment services via audio-only/telephone;
- Continue providing payment rates for services via telehealth at the same level as in-person services;
    - Incorporate reimbursement for overhead and administrative costs imposed by implementation of technology and delivery of services via telehealth including new roles for support staff;
- Continue reimbursing hospitals the facility fee for partial hospitalization programs and other outpatient department services when patients receive these services at their home via telehealth;
- Continue allowing other types of providers, including licensed clinical social workers, clinical psychologists, and therapists as well as physicians, the ability to provide behavioral healthcare via telehealth to both new and established patients for telehealth; and

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- Continue allowing physicians to supervise care provided by other practitioners through audio and video communication.

Conclusion
Adopting fewer burdensome requirements and maintaining coverage of telehealth would help the nation's behavioral healthcare providers who are facing increased costs and preparing for a surge in patients with mental health and addiction problems. We expect the patient caseload to increase significantly as Covid-19 continues to have devastating effects on all Americans, including our healthcare workforce.

If you have questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Thank you for your consideration.

Sincerely,

Shawn Coughlin
President and CEO

About NABH
The National Association for Behavioral Healthcare (NABH) advocates for behavioral healthcare and represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty behavioral healthcare programs, and recovery support services in nearly all 50 states. The association was founded in 1933.

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[i] Kaiser Family Foundation, "Health Tracking Poll – Early April 2020: The Impact of Coronavirus on Life in America", published online April 2, 2020; Erica Hutchins Coe, Kana Enomoto, "Returning to Resilience: the Impact of Covid-19 on mental health and substance use", published online by McKinsey and Company, April 2020.
[ii] Laura Hawryluck, Wayne L. Gold, Susan Robinson, "SARS Control and Psychological Effects of Quarantine, Toronto, Canada", *Emerg Infect Dis*, July 2004, vol.10 no.7, 1206–1212; Sara Reardon, "Ebola's mental-health wounds linger in Africa: health-care workers struggle to help people who have been traumatized by the epidemic", *Nature*, vol. 519, no. 7541, 2015, p. 13; Emily Goldmann and Sandro Galea, "Mental health consequences of disasters," *Ann Rev Public Health*, Volume 35, pp. 169–83, 2014, available online.
[iii] William Wan, "The coronavirus pandemic is pushing America into a mental health crisis", Washington Post, May 4, 2020.
[iv] Mayowa Oyesanya, Javier Lopez-Morinigo, Rina Dutta, "Systematic review of suicide in economic recession", *World J Psychiatry*, vol. 5, no. 2, 243-54, June 22, 2015, available online.
[v] Holly Hedegaard, Sally C. Curtin, Margaret Warner, Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief, "Increase in Suicide Mortality in the United States, 1999-2018", , April 2020, available online.
[vi] NABH Report on "The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities", March 2019, available online.

[vii] Exec. Order No. 13924, "Regulatory Relief to Support Economic Recovery", 85 Fed. Reg. 31353, May 19, 2020, available online.
[viii] See 42 CFR 482.60, Special Provisions applying to psychiatric hospitals; 42 CFR 482.61, Special medical record requirements for psychiatric hospitals, and 42 CFR 482.62, Special staffing requirements for psychiatric hospitals.
[ix] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of March 31, 2020, available online.
[x] McKinsey & Company, "Covid-19 Response: Behavioral Health & Health-related Basic Needs", April 7, 2020 presentation; Merritt Hawkins, "2017 Review of Physician and Advanced Practitioner Recruiting Incentives", available online.
[xi] Shannon Mace, Adriano Boccanelli, Megan Dormond, "The Use of Telehealth withing Behavioral Health Settings: Utilization, Opportunities, and Challenges", Behavioral Health Workforce Research Center, University of Michigan, March 2018, available online.