National Association for Behavioral Healthcare

Access. Care. Recovery.

SUBMITTED VIA E-MAIL: Erin.McMullen@macpac.gov

Penny Thompson, MPA, Chair
Medicaid and CHIP Payment and Access Commission
1800 M Street, NW, Suite 650 South
Washington, DC 20036

31 May 2019

Dear Ms. Thompson:

The National Association for Behavioral Healthcare (NABH) thanks you for this opportunity to comment on the regulatory environment for Institutions for Mental Diseases (IMDs). On behalf of our more than 1,000 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, and outpatient networks, we appreciate the commission's effort to examine requirements and standards for IMDs and inform Congress about this complex topic.

Regulations

It is important to understand that IMDs must adhere to a host of regulations—including many federal requirements—even though many of these facilities are not eligible for Medicaid payments. For example, inpatient behavioral healthcare hospitals that meet the definition of an IMD treat Medicare patients and therefore must comply with Medicare's regulatory requirements. These IMDs must adhere to:

- the conditions of participation (CoP) that all other hospitals must meet when they agree to take Medicare patients;
- the "special" CoPs applicable to psychiatric hospitals, known as "B-tags";
- certification requirements of Centers for Medicare & Medicaid Services (CMS)-approved accreditation organizations, such as the Joint Commission (TJC); and
- unannounced surveys by state surveyors and CMS-approved accreditation organizations for purposes enforcing these provisions.

NABH's recent report *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities* for the first time examined and quantified the cost of some of these regulations. In this study, our researchers concluded that three federal areas impose $1.7 billion in compliance costs on inpatient psychiatric hospitals (including IMDs) each year. This financial burden represents 4.8 percent of an average facility's annual revenue for all inpatient psychiatric services from all sources. The bulk of the costs relates to compliance with B-tags and ligature-risk requirements.

B-Tags

CMS has issued interpretive guidance related to psychiatric hospital special CoPs, in which the agency defines 60 distinct compliance elements as B-tags. The guidance describes survey protocols for verifying compliance and identifying deficiencies. CMS has not significantly updated the interpretative guidance for the B-tags since the 1980s. The B-tags impose large costs on providers, mostly through low-value documentation requirements. Nationwide, the B-tags impose an estimated $622 million in compliance costs for inpatient psychiatric hospitals each year. These are a few examples of B-tags that are particularly burdensome to providers:

- Providers must comply with detailed requirements for comprehensive "treatment plans" and "progress notes" (Tags B104 through B132). These requirements not only constrain a clinician's professional judgment, they also impose immense documentation burdens that add little value.

- Inpatient psychiatric facilities (including IMDs) must appoint a director of nursing services (Tag B147). Some surveyors enforce a rigid academic requirement, demanding that all nursing directors have a master's degree in psychiatric or mental health nursing, regardless of alternative training or practical experience.

- Upon admission, each patient must receive a psychiatric evaluation (Tag B110). Some surveyors require that a psychiatrist conduct this evaluation, even if the evaluation falls within the scope of practice for an advanced practice clinician (APC), such as a nurse practitioner (NP) or physician assistant (PA).

Ligature Risk

In 2017 CMS announced that the "safe setting" CoP requires inpatient psychiatric facilities to address "ligature risk points," defined as locations where a patient might attach a cord-like object for the purpose of hanging or self-strangulation. Ligature points may include hand rails, door knobs and hinges, shower curtain rods, exposed plumbing or pipes, soap and paper towel dispensers, ceiling projections such as light fixtures or sprinkler heads, call bell cords, and medical equipment power cords.

Psychiatric providers care first and foremost about keeping patients safe, which includes protecting patients from self-harm or suicidal behaviors. However, it's not feasible for providers to create "ligature-free" environments that are completely devoid of potential ligature-attachment points. Nonetheless, some surveyors demand major changes to psychiatric facilities' infrastructure or staffing to address perceived issues that carry a minimal risk for patient harm. In our study, NABH facilities reported that, on average, it costs more than $15,600 per psychiatric bed in physical plant and equipment costs to address ligature-related issues.

Residential Substance Use Disorder (SUD) Treatment IMDs

Not all IMDs are inpatient hospitals. Some are residential treatment programs that must comply with an equally important, though separate, set of regulations that are predominantly state-based. Each state regulates these programs differently via licensure, certification, and other state-based statutory and regulatory requirements. Many states also have requirements that residential SUD treatment IMDs meet certain staffing requirements such as keeping a medical director on staff, providing treatment and discharge plans, and reporting a wide range of data.

In addition, most residential IMDs receive their accreditations from third-party accreditors, such as TJC or the Commission on Accreditation of Rehabilitation Facilities (CARF), the largest accrediting body for addiction treatment programs. Accreditation from CARF or TJC fulfills state- licensing requirements, and the accreditation standards from these organizations are typically higher than state-licensing requirements. For example, CARF requires addiction providers to use "current research, evidence-based practice, peer-reviewed scientific and health publications, clinical practice guidelines and/or expert professional consensus." Additionally, CARF-accredited providers must have individualized treatment plans, something that TJC also requires.

Quality Standards

Not only are IMDs highly regulated, they also are required to meet or report on a growing number of quality measures, such as the Medicare program's Inpatient Psychiatric Facility Quality Reporting (IPFQR) program.

Before CMS released its fiscal year 2019 Inpatient Psychiatric Facility Prospective Payment System Rule, the IPFQR program required inpatient psychiatric facilities (many of which are IMDs) to document, abstract, and report as many as 44 data points (a very conservative estimate) for each patient. This estimate does not include the number of data points required for demographic data, diagnosis codes (which could number as many as 25 elements per patient), and procedure codes. Most of the data are extracted manually and must be reported manually. The numerator for each of the transition measures (NQF 647 and 648) contains 11 discrete items. If any of the combined 22 items is not reported, then the measure set is considered incomplete, which jeopardizes an organization's reimbursement.

In addition, the psychiatric care industry is currently facing a workforce shortage. Consequently, organizations are evaluating carefully how their professionals spend their time. We have heard consistently that providers feel the IPFQR dataset drains staff time from clinical care without a concomitant benefit.

NABH members are equally concerned about the burden these measures impose on patients. Our members care for patients who have acute psychiatric illnesses and need to be stabilized in a crisis. Lengths of stay are very short. Demands on patients must be prioritized.

The NABH Quality Committee has identified a set of principles that our members believe that all performance measurement and outcomes data-collection efforts should follow:

1. Improve the effectiveness and efficiency of patient care;

2. Focus on indicators that provide the most useful clinical and operational data possible;

3. Focus on indicators that are reasonable for organizations to collect and later act on;

4. Provide a balance between the level of intensity to collect data and the value and purpose of that data;

5. Offer potential to be used for measurably improving healthcare processes, outcomes, efficiency, and patient experiences.

Other IMD-related Issues

Section 5012 of the *SUPPORT for Patient and Communities Act* states MACPAC shall "submit to Congress a report on at least the following information" and then lists the items MACPAC indicated in a letter to stakeholders. This section leaves room for MACPAC to report on other issues affecting IMDs, and we encourage MACPAC to include two additional issues in its report to Congress. These are:

Claw-back on Payments to IMDs Under Medicaid Managed Care

On May 6, 2016, CMS issued a long-anticipated final rule that updated the Medicaid and Children's Health Insurance Program (CHIP) managed care regulations to better align these rules with existing commercial, marketplace, and Medicare Advantage regulations. Among the provisions included in the final rule was one that gave managed care organizations (MCOs) flexibility to address the IMD exclusion.

The rule allows Medicaid health plans that are at-risk, capitated plans to contract with IMDs, including psychiatric hospitals and crisis residential settings for up to 15 days per month. "It does permit a patient to

stay beyond 15 days if that stay spans a two-month period with no more than 15 days occurring in a single month, or if the state uses state-only, non-Medicaid dollars for the patient days that extend beyond 15 days."

In the final rule, CMS noted "If an enrollee has a length of stay for more than 15 days within the period covered by the monthly capitation payment, no capitation payment may be made for that enrollee under a Medicaid managed care program regulated under 42 CFR part 438." CMS continues to explain that the "appropriate application of the in lieu of services policy for use of an IMD requires the MCO or PIHP to determine if the enrollee has an inpatient level of care need that necessitates treatment for no more than 15 days. If the managed care plan (or physician) believes that a stay of longer than 15 days is necessary or anticipated for an enrollee, the use of this specific in lieu of service is likely not appropriate if Medicaid coverage is going to be continued."

This language about the 15-day cap has caused confusion in the industry. Some MCOs have interpreted this part of the final rule to mean IMDs should pay back the MCOs for all of the care provided for the first 15 days if a patient stays beyond day 15. This means IMDs would be required to provide, in some cases, tens of thousands of dollars in care without compensation.

NABH interprets this section of the final rule differently. We believe that it requires MCOs to pay back the monthly capitation payment they have received; however, the rule is silent on how to coordinate payments from MCOs to IMDs. Therefore, NABH interprets this final rule to mean CMS does not intend for IMDs to repay MCOs, and instead allows MCOs and IMDs to resolve those payment arrangements in the contracting process.

Given the confusion surrounding this important issue, it would be helpful if CMS clarified that MCOs are required to pay back the monthly capitation payment for patients who stay in an IMDs for more than 15 days. We would also like the CMS agency to clarify that the rule does not cover repayments between IMDs and MCOs, which should be addressed during the privately negotiated contract process between IMDs and MCOs.

Medicaid Provider Numbers in States that Do Not Reimburse IMDs

Another issue that MACPAC and Congress should be aware of relates to IMDs, dual-eligible beneficiaries in the Medicare and Medicaid programs, and allowable bad debt. As you may know, bad debt occurs when Medicare-certified healthcare providers that file an annual Medicare cost report cannot collect out-of-pocket payments from their patients (i.e., deductible and coinsurance payments) after these providers have made a reasonable effort to collect. Medicare reimburses healthcare providers for some bad debt generated by Medicare beneficiaries, which is known as "allowable bad debt."[1]

For dual-eligible beneficiaries, the out-of-pocket obligations that Medicaid does not cover are included in Medicare's allowable bad debt. However, for a facility to claim bad debt on its Medicare cost report, the facility must receive a formal claim denial from the state Medicaid program. The purpose of that denial is so the facility can demonstrate to the Medicare program that the state will not cover the patient's deductible and/or coinsurance payment. States usually deny claims because Medicaid payments are typically less than Medicare payments. Therefore, under crossover payment rules, the state will generally deny payment. After the provider's claim has been denied, the provider can request bad debt reimbursement from the Medicare program.

[1] Current Medicare regulations at 42 CFR §413.89(h) require the Medicare program to reimburse hospital providers sixty five percent (65%) of allowable bad Medicare debt.

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The problem for many IMDs is that they treat dual-eligible beneficiaries from multiple states and cannot get a Medicaid provider number because the state where the patient is a resident does not reimburse IMDs. Consequently, the IMD cannot file a claim and receive the necessary pro forma denial to show Medicare that it has a case of allowable bad debt. As a result, NABH members affected by this issue are losing hundreds of thousands of dollars in reimbursement annually because of an administrative technicality.

Conclusion

We look forward to continuing our work with MACPAC to help identify other opportunities for a more flexible and efficient Medicaid program through regulatory, sub-regulatory, policy, practice, and procedural changes.

If you have questions, please contact me directly at 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs Scott Dziengelski at 202-393-6700, ext. 115. Thank you for the opportunity to provide feedback.

Sincerely,

President and CEO