

**National
Association
for Behavioral
Healthcare**



Access. Care. Recovery.

The High Cost of Compliance:

Assessing the Regulatory
Burden on Inpatient
Psychiatric Facilities

MARCH 19, 2019

*NABH commissioned
Manatt Health to
conduct this report.*

manatt

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EXECUTIVE SUMMARY

Inpatient psychiatric facilities operate under a heavy burden of federal regulatory requirements. The National Association for Behavioral Healthcare (NABH) commissioned Manatt Health to assess the burdens that certain federal laws and regulations impose on inpatient psychiatric facilities. This report focuses on three federal regulatory domains that attach to participation in the Medicare program:

1. The so-called “B-tag” requirements, a detailed set of standards for patient evaluations, medical records, and staffing in inpatient psychiatric facilities. These conditions of participation (CoPs) are defined in regulations by the Centers for Medicare & Medicaid Services (CMS), and discussed at length in CMS’ interpretive guidance.
2. The requirement to address “ligature risk points,” meaning aspects of the physical environment that a patient could use to attempt self-strangulation. CMS has directed inpatient psychiatric facilities to address ligature risk as part of the CoP that requires all hospitals to provide care “in a safe setting.”
3. The Emergency Medical Treatment and Labor Act (EMTALA), which obligates a hospital to screen all patients for emergency medical conditions and, if an emergency condition is identified, to stabilize the patient before the patient may be discharged or transferred.

These rules are intended to serve the important goals of patient safety and high-quality care. However, some of them are now outdated and many of them are applied inconsistently by on-the-ground surveyors, exposing providers to unpredictable citations and requiring costly alterations in their procedures, equipment, and facilities.

Based on our survey of 62 inpatient psychiatric facilities, we estimate that these three regulatory areas, taken together, impose **\$1.7 billion in compliance costs each year nationwide**. Put another way, these burdens represent **4.8 percent of an average facility's annual revenue** for all inpatient psychiatric services from all sources.

CMS should rationalize these regulations to minimize the burden on providers, especially in areas where provider compliance costs could be reduced without significantly affecting patient care. Adopting less burdensome requirements would benefit the healthcare system overall by reducing unnecessary costs, and by bringing greater stability and predictability for providers as they navigate the regulatory environment. In addition, patients may directly benefit from reduced regulatory burden as clinicians are able to shift more of their attention—and facilities are able to shift more of their resources—away from compliance for compliance's sake and toward initiatives that meaningfully contribute to safe, high-quality care.

The B-tag Requirements: Key Findings and Recommendations

CMS issued the CoPs in 1966 and the interpretative guidance in the 1980s; neither the rules nor the guidance for psychiatric patient evaluations, medical records, and staffing have been meaningfully updated since their issuance. As enforced today, the B-tags produce frequent citations and impose large costs on providers, mostly through low-value documentation requirements. Among our respondents, almost 80 percent of freestanding psychiatric hospitals report at least one B-tag citation in their most recent three compliance surveys. Nationwide, the B-tags impose an estimated \$622 million in compliance costs each year. Many in the industry believe that these requirements are no longer appropriate in today's environment of care, and should be eliminated wholesale. We recommend that CMS convene a commission (with representation from inpatient psychiatric providers) to determine whether these psychiatric hospital CoPs remain relevant, and whether some—or all—of them should be revised or discarded. In this report, we highlight examples of B-tags that merit revision, including the following:

- Providers must comply with detailed requirements for comprehensive “treatment plans” and “progress notes” (Tags B104 through B132). These requirements not only constrain clinician's professional judgment, but also impose immense documentation burdens that add little value. CMS should revise these requirements to be less prescriptive. CMS should also direct surveyors to limit their review to whether a provider has adopted a reasonable approach to compliance; surveyors should not select and enforce a *particular* approach among a set of reasonable alternatives.
- Inpatient psychiatric facilities 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, irrespective of alternative training or real-world experience. CMS should underscore to surveyors that, consistent with the CMS rule, a nursing director may be designated based on competence in lieu of a specialized master's degree.
- Upon admission, each patient must receive a psychiatric evaluation (Tag B110). Some surveyors require that this evaluation be conducted by a *psychiatrist*, 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. CMS should clarify to surveyors that each facility may designate clinicians to perform patient psychiatric evaluations, subject to applicable state licensure laws that define clinical scope of practice.

Ligature Risk: Key Findings and Recommendations

Psychiatric providers care deeply about keeping patients safe, which includes protecting patients from self-harm or suicidal behaviors. As CMS has recognized, however, providers cannot feasibly 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 only minimal risk for patients in that setting. Approximately 60 percent of our respondents reported a ligature-related citation in the last two years. When asked about costs over the last five years and the projected next fiscal year, respondent facilities reported, on average, more than \$15,600 *per psychiatric bed* on physical plant and equipment costs to address

ligature-related issues. To address this issue, CMS should issue guidance that achieves the following:

- Standardize survey practices by adopting an evidence-based approach. Identify design areas or equipment categories of particular concern so providers are on notice of areas that surveyors will scrutinize most closely. Moreover, surveyors should not be permitted to demand modifications—especially immediate, large-scale modifications—absent an empirical basis for believing that those modifications would meaningfully improve patient safety.
- Minimize the risk of redundant renovations. After a surveyor accepts a particular design feature as ligature-resistant, future surveyors should not be permitted to issue citations based on that approved feature for a prescribed period (e.g., three years), absent special circumstances.
- Clarify that inpatient psychiatric facilities need not design highly ligature-resistant physical spaces in areas that are under constant supervision, such as nursing stations and cafeterias.

EMTALA: Key Findings and Recommendations

Congress passed EMTALA to ensure that any patient who presents to an emergency department (ED) would be screened for emergency medical conditions and, if necessary, stabilized, irrespective of the patient's ability to pay. In recent years, however, some regulators have begun interpreting EMTALA in a manner that imposes new requirements on psychiatric facilities.

- EMTALA permits each provider to determine which clinicians are designated as “qualified medical persons” (QMPs) who may screen patients for emergency medical conditions. Some regulators, however, are using EMTALA to raise the baseline licensure requirements for QMPs in inpatient psychiatric facilities.¹ This approach upends decades of accepted clinical practice, and fails to account for widespread shortages of clinicians with psychiatric expertise. Among respondents who made changes in response to this new interpretation, the average cost was more than \$900 per 100 days of inpatient care. CMS and the U.S. Department of Health & Human Services Office of Inspector General (OIG) should ensure that surveyors

respect EMTALA's clear direction that each provider's medical staff may decide for itself which clinicians are competent to screen for emergency medical conditions, subject to applicable state licensure laws that define clinical scope of practice.

- Some psychiatric facilities do not accept involuntarily committed patients, and have long maintained a policy of transferring such patients to more appropriate facilities, often in accordance with standing transfer agreements established under state-run programs. Some regulators, however, are now requiring all inpatient psychiatric facilities with an ED to admit involuntarily committed patients, notwithstanding the risks for other patients and for hospital staff when patients are admitted involuntarily absent proper precautions, including additional staffing and training. EMTALA should not be used to address the shortage of facilities that treat involuntarily committed patients. Federal regulators should respect state procedures for involuntary commitment, including state arrangements for facility designation and patient transfer.

¹ For acute care hospitals, some regulators require a psychiatrist rather than an ED physician or advanced practice clinician APC, such as an NP. For freestanding psychiatric hospitals, some regulators require that emergency screenings be conducted by an APC rather than a registered nurse or licensed clinical social worker.

INTRODUCTION

Inpatient psychiatric facilities offer critical support to Americans with severe mental health needs. Only 16 percent of licensed mental health facilities offer acute inpatient services, providing round-the-clock care for patients with psychiatric emergencies.² These inpatient psychiatric facilities—which include freestanding psychiatric hospitals, as well as inpatient psychiatric units within acute care hospitals—help patients through times of crisis until it is safe for them to continue treatment in a community setting (or, if appropriate, to transfer to a residential facility for long-term care).

Government regulation and oversight play a critical role in ensuring that patients receive quality care in a safe setting. To that end, the federal government has defined myriad requirements for hospitals, as well as an additional set of rules specific to inpatient psychiatric facilities. Complying with all those rules comes at a cost, however. The Centers for Medicare & Medicaid Services (CMS), the primary federal regulator of healthcare facilities, has itself recognized the value in periodically reassessing a rule's impact to ensure that its benefits outweigh the costs of compliance. In October 2017, CMS Administrator Seema Verma announced the “Patients Over Paperwork” initiative, which aims to improve the patient experience while decreasing the “hours and dollars clinicians and providers spend on CMS-mandated compliance.”³

NABH commissioned Manatt Health to assess the burdens that certain federal laws and regulations impose on inpatient psychiatric facilities. This report will focus, in particular, on the following three areas:

1. A set of CMS regulations specific to psychiatric facilities regarding medical records, patient evaluation, and staffing requirements. These requirements are commonly referred to as the “B-tags” in reference to CMS’ detailed interpretive guidance, which assigns a “tag” number to each element that must be verified during an on-site compliance survey.
2. The need 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. CMS

has directed psychiatric facilities to address ligature risk as part of the general requirement to provide care “in a safe setting.”

3. The Emergency Medical Treatment and Labor Act (EMTALA), also known as the “anti-dumping” law, which requires hospitals to perform medical screenings by a “qualified medical person” QMP for all patients who presents to an emergency department ED, regardless of ability to pay. If an emergency condition is identified, EMTALA prohibits hospitals from discharging or transferring a patient from the ED until the patient is stabilized. In recent years, some regulators have begun interpreting EMTALA in a manner that imposes new requirements on psychiatric facilities with respect to clinical staff qualifications for a QMP and treatment of patients brought to the hospital against their will for involuntary commitments.

These three sets of requirements apply to all inpatient psychiatric facilities that participate in the Medicare program, which represents approximately 90 percent of psychiatric hospitals and virtually all general hospitals with psychiatric units.⁴

This report seeks to: (1) define and measure the various types of burdens imposed by each of these three regulatory areas, (2) highlight requirements where the burden outweighs any significant value for patient safety or quality of care, and (3) explore avenues for alleviating provider burden while supporting safe and effective care.

The report’s findings and recommendations were developed using a multimodal approach. In addition to compiling research on these requirements and background issues, the authors conducted a survey on a stratified sample of general hospitals with psychiatric units and specialized psychiatric hospitals, encompassing 62 facilities in 18 different large and small health systems around the country. Survey data was supplemented by in-depth qualitative interviews with a subset of survey respondents. For more information on the study methodology, see Appendix A. In the interests of confidentiality, all survey responses and case studies have been anonymized.

² Substance Abuse and Mental Health Services Administration (SAMHSA), *National Mental Health Services Survey (N-MHSS): 2017. Data on Mental Health Treatment Facilities* (Aug. 2018), https://www.dasis.samhsa.gov/dasis2/nmhss/2017_nmhss_rpt.pdf.

³ CMS, *Patients Over Paperwork: December 2017 Newsletter*, <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html>.

⁴ *National Mental Health Services Survey*, cited above in note 2.

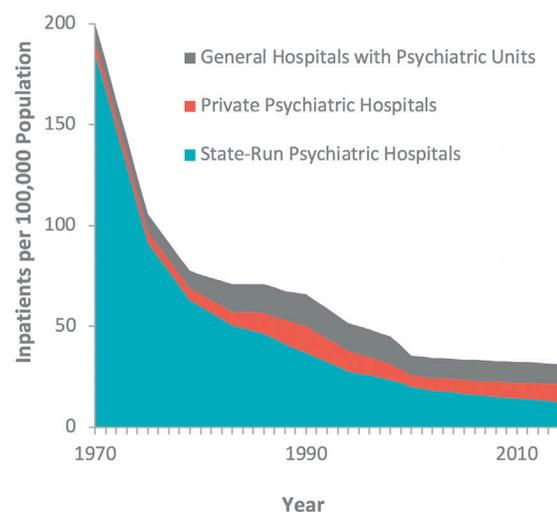
Before detailing our findings, we begin this report by providing important context as to historical developments concerning inpatient psychiatric facilities and the current status of America's network of care for individuals with severe mental and healthcare needs.

Background: Nationwide Trends and Unmet Psychiatric Care Needs

America's psychiatric care landscape has undergone a radical transformation over the last 60 years. The dominant model of psychiatric care in the 1950s centered around long-term care in large, state-run hospitals. Advances in medical treatment and changing social attitudes offered the hope that many individuals could live safely in the community. Further, a legal right to community living took shape in courts and legislatures around the country. States began shuttering their hospitals, causing the number of state-funded psychiatric beds per capita to plummet by 97 percent between 1955 and 2016.⁵ It seems, however, that governments have not fully compensated for the loss of these facilities, even though mental and behavioral health conditions affect nearly 20 percent of Americans each year, ranking among the leading causes of disability and premature death.⁶ Today, accounting for both public and privately run facilities, America's per capita psychiatric inpatient bed count is approximately 70 percent lower than the average among developed nations.⁷

Access to psychiatric care is a problem: in a 2018 survey, only one in four respondents thought that mental health services were accessible for everyone.⁸ The primary reported barriers included a shortage of nearby providers who were accepting new patients and poor insurance coverage. Emergency departments are increasingly used to fill the access gap: mental and behavioral health issues now account for at least one out of every eight visits to the emergency department.⁹ Many of these psychiatric emergencies could be avoided if Americans had better access to services, including inpatient psychiatric services.

Figure 1. Inpatients per capita at public and private inpatient psychiatric facilities, 1970–2014



Source: National Association of State Mental Health Program Directors, *Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 To 2014* (Aug. 2017), https://www.nasmhpd.org/sites/default/files/TACPaper.2.Psychiatric-Inpatient-Capacity_508C.pdf

We recognize that the targeted proposals in this report will not, standing alone, address the deeper problems of inadequate access to behavioral healthcare. Beyond implementing the reforms proposed here, therefore, Congress, CMS, and the states should consider broader solutions aimed at bolstering access to sustainable mental and behavioral services, especially for the most vulnerable individuals with particularly acute care needs or barriers to access.¹⁰ Among other issues, legislators and regulators should consider eliminating the Medicaid program's exclusion of coverage for so-called "institutions of mental disease," as well as the Medicare program's 190-day lifetime limit on coverage for inpatient psychiatric care.¹¹ Government officials should also vigilantly enforce parity laws that prohibit health plans from imposing limitations on mental or behavioral healthcare services that do not apply to medical services.¹²

⁵ Doris A. Fuller et al., *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*, Treatment Advocacy Center (June 2016), <https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf>.

⁶ American Psychiatric Ass'n, *Mental Health Disparities: Diverse Populations* (2017), <https://www.psychiatry.org/psychiatrists/cultural-competency/mental-health-disparities>.

⁷ Tarun Bastiampillai et al., *Increase in US Suicide Rates and the Critical Decline in Psychiatric Beds*, *Journal of the Am. Med. Ass'n*, Vol. 316, No. 24 (2016), <https://jamanetwork.com/journals/jama/fullarticle/2580183>.

⁸ Cohen Veterans Network & National Council for Behavioral Health, *America's Mental Health 2018* (Oct. 10, 2018), <https://www.cohenveteransnetwork.org/AmericasMentalHealth/>.

⁹ Audrey J. Weiss et al., *Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006–2013*, Agency for Healthcare Research & Quality, Healthcare Cost and Utilization Project Statistical Brief #216 (Dec. 2016), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf>.

¹⁰ See, for example, the recommendations for systemic reform offered by the Treatment Advocacy Center in their report *Going, Going, Gone*, cited above in note 5.

¹¹ NABH, *IMD Exclusion*, <https://www.nabh.org/policy-issues/imd-exclusion/>; NABH, *190-Day Lifetime Limit*, <https://www.nabh.org/policy-issues/medicare/190-day-lifetime-limit/>.

¹² NABH, *Parity*, <https://www.nabh.org/policy-issues/parity/>.

Regulatory Burdens on Inpatient Psychiatric Facilities

Inpatient psychiatric facilities provide crucial services that are in high demand in communities across the country. A recent survey found that many psychiatric facilities were operating at or near capacity, with the top quartile of facilities experiencing occupancy rates above 85 percent.¹³ Moreover, inpatient psychiatric facilities face significant financial challenges, as documented in their cost reports. As of 2016, more than half of the nation's 1,738 inpatient psychiatric facilities had negative net operating margins.¹⁴ The *average* net operating margin for inpatient psychiatric facilities was negative 5 percent—roughly the same order of magnitude as the cost of complying with the regulatory areas assessed in this report. Reducing those burdens would play a role in improving patient access by freeing up inpatient psychiatric facilities' time, financial resources, and in certain cases, actual beds.

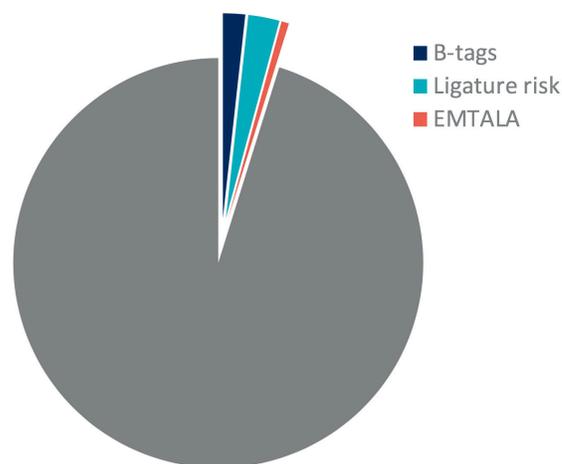
In particular, this report highlights requirements that impose burdens on providers without offering commensurate benefits to patients. Certain requirements put in place decades ago may be a poor fit for modern clinical realities; in other cases, regulators are modifying decades-old interpretations, stretching laws beyond their original scope and purpose. The interpretations often vary by surveyor or region in unexpected or inconsistent ways, making it difficult for facilities to maintain compliance. Many facilities end up redesigning their policies and physical spaces time and time again to satisfy the surveyor rather than to improve care quality or patient safety.

The Potential Cost Impact

Based on our survey results, we estimate that the three regulatory areas discussed in this report collectively impose an average annual cost of \$1.7 billion on America's inpatient psychiatric facilities. Per year, this translates to an average of just under \$1 million per facility, or more than \$18,000 per licensed psychiatric bed. On a per-day-of-patient-care basis, these costs equal an estimated \$6,747 for every 100 days of inpatient psychiatric care provided. (We will use this metric—cost per 100 patient days, or daily cost for a 100-bed facility at full occupancy—throughout this report.)

To put these numbers in context, we will also report these per-day costs as a percentage of total spending on inpatient psychiatric care—that is, the revenue psychiatric facilities receive as payment from all sources for the inpatient psychiatric services they provide. Overall, in fiscal year 2019, psychiatric hospitals received an estimated \$35.4 billion in inpatient psychiatric service payments.¹⁵

Figure 2. Areas of regulatory burden as a proportion of an average facility's inpatient psychiatric care revenue



Thus, the combined cost of all three regulatory areas amounts to approximately 4.8 percent of an inpatient psychiatric facility's revenue for inpatient psychiatric services. That is a substantial percentage for facilities with such tight financial constraints, especially when, according to our survey respondents, many of these regulatory areas currently contribute little to ensuring high-quality care.

The pages that follow identify opportunities to rationalize federal regulations and enforcement. By reducing burdens on providers without compromising patient safety, these reforms will support the long-term sustainability of the psychiatric inpatient system and access to care for vulnerable individuals.

¹³ NABH, *2018 NABH Annual Survey*, <https://www.nabh.org/2018-annual-survey/>.

¹⁴ Authors' tabulation of 2016 Hospital Cost Report (HCRIS) public use files, provided by CMS, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospital-2010-form.html>

¹⁵ SAMHSA, *Behavioral Health Spending & Use Accounts 2006–2015*, HHS Pub. No. (SMA) 19-5095 (2019), <https://store.samhsa.gov/system/files/bhsua-2006-2015-508.pdf>.

This figure represents *net* inpatient revenue, which, in the healthcare context, refers to revenue net of contractual allowances and other discounts.

THE B-TAG REQUIREMENTS

The first regulatory area we assessed pertains to CMS regulations that define mandatory CoPs for all providers who participate in the Medicare program. The agency evaluates compliance with these requirements through regular on-site surveys. Inpatient psychiatric facilities must satisfy the CoPs that apply to all general hospitals, as well as additional CoPs that address psychiatric patient evaluations, medical records, and staffing (which are set forth in full in Appendix C).¹⁶ CMS has issued 60 pages of interpretive guidance with respect to the psychiatric hospital CoPs, in which the agency defines 60 distinct compliance elements (referred to as “B-tags”), one or more for each CoP.¹⁷ The guidance describes survey protocols for verifying compliance and identifying deficiencies. CMS has itself recognized that B-tags are ripe for reconsideration, flagging them as one of several areas for review under the “Patients Over Paperwork” initiative.¹⁸ This review is well-merited.

CMS’ rules and guidance are highly prescriptive in some cases, but appear to provide flexibility in others, at least in theory. These detailed provisions make compliance challenging all on their own. Compounding those difficulties, however, is the immense variability among individual surveyors in how they interpret the guidelines when assessing facilities’ compliance, including the degree to which surveyors allow facilities the flexibility afforded to them under CMS’ guidance. These surveys may be conducted by CMS personnel, state health agencies, or The Joint Commission (TJC), a CMS-approved private accreditation organization. A facility that is found to be out of compliance with the CoPs must correct the deficiency within the required timeframe—typically 90 days—or be subject to termination from the Medicare program.

Out of the 60 individual B-tags contained within the CoPs, we focus here on two sets of B-tags that our survey respondents identified as particularly problematic: first, requirements related to documentation in the patient’s medical record, and second, requirements related to minimum qualifications for certain director-level administrative staff. Taken together, the compliance costs for these two sets of B-tags amount to 1.8 percent of inpatient psychiatric care spending, imposing approximately \$625 million in costs every year on America’s psychiatric facilities.

Quick Facts

Regulatory Burden: The B-tags

| | |
|---|----------------|
| Estimated national annual costs (millions) | \$625.9 |
| Average cost per day for a 100-bed facility | \$2,461 |
| Average cost as a percentage of all-payer revenue for inpatient psychiatric services | 1.8% |
| Average annual cost per licensed psychiatric bed | \$6,698 |
| Percentage of freestanding hospitals that were cited on a B-tag issue during their last 3 surveys | 77% |
| Among cited hospitals, percentage receiving a condition-level deficiency | 52% |

The Documentation Requirements are Prescriptive and Outdated

Every hospital, psychiatric or otherwise, is required to maintain a comprehensive medical record for each patient that receives care.¹⁹ CMS goes a step further for inpatient psychiatric facilities, however, using the B-tags to specify numerous details that must be documented in precise ways. Notably, the clinical staff must draft an “individualized treatment plan” for each patient with elements such as the

¹⁶ The hospital CoPs are codified at 42 C.F.R. Part 482. Subpart E lists two “special” CoPs applicable to specialty psychiatric hospitals, each of which defines multiple independent standards. Largely identical regulations for psychiatric units within general hospitals appear at 42 C.F.R. § 412.27.

¹⁷ CMS, State Operations Manual (SOM), Appendix AA, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_aa_psyc_hospitals.pdf. Beyond the scope of this report is the extent to which this interpretative guidance represents a proper exercise of authority by CMS. The Supreme Court of the United States recently heard argument on a related issue in *Azar v. Allina Health Services*, Docket No. 17 1484 (argued Jan. 15, 2019).

¹⁸ CMS, Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction, 83 Fed. Reg. 47686, 47703–04 (Sept. 20, 2018).

¹⁹ 42 C.F.R. § 482.24.

patient's strengths and weaknesses, short- and long-term goals, and planned therapeutic interventions. The plan must be updated periodically with "progress notes" that connect treatment results back to the goals listed in the plan. Those requirements may sound reasonable, but the level of detail and frequency of updates required are no longer appropriate due to seismic shifts in the model of inpatient psychiatric care.

When the psychiatric hospital CoPs were first issued in the mid 1960s—and when the current version of the B-tag guidance was issued mid 1980s—many psychiatric inpatients remained hospitalized for months or even years, and occasionally languished with only minimal medical attention.²⁰ Therefore, CMS sought to ensure that patients were receiving "active" treatment by, among other things, requiring that each patient's treatment plan specify which clinicians would provide which therapies on which days, and requiring that progress notes track the patient's improvement on specific short- and long-term goals.

Example: Compressed Timeline for Progress Notes

The regulation: "The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter." (42 C.F.R. § 482.61(d))

The interpretive guidance: Progress notes may be "shift notes, weekly notes, or monthly notes," but should be written with "greater frequency when patients are more acutely ill and/or in a crisis." (Tags B125 & B126)

The surveyors: According to our respondents, many surveyors expect to see *daily* progress notes that connect *each therapeutic intervention* back to the goals in the treatment plan.

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 inpatients so they can safely return to the

community as soon as possible and continue care in an outpatient setting. Therefore, clinicians now have only a few days to produce the same amount of documentation that may previously have been drafted and updated over a series of weeks, or months. (See the call-out box for an example.) What's more, many of those required steps are no longer necessary for many patients, especially when compared with medical (non-psychiatric) inpatients with comparable lengths of stay.

Exacerbating these problems further, the surveyors who assess compliance exhibit variable and inconsistent interpretations of the B-tag requirements. Although CMS' guidance states that each facility may select its own "format for treatment plans and treatment plan updates,"²¹ surveyors often leave little room for flexibility or professional judgment. Instead of confirming that a facility has adopted reasonable compliance measures to meet a particular B-tag, some surveyors—who may or may not have psychiatric expertise—insist that providers adopt a *particular approach*. These approaches often do not improve the treatment plan or patient care, and may fail to account for the unique circumstances of a particular facility or patient population. In many instances, the required changes appear to reflect the individual surveyor's gloss on CMS' guidelines, or even the surveyor's personal opinion about best practices.

"Because of the treatment plan B-tags, we spend a lot of time 'treating the medical record' instead of treating the patient."

—Executive responsible for clinical services at multiple freestanding psychiatric hospitals

For example, Tag B121 specifies that a treatment plan should list patients' short- and long-term goals, but the interpretive guidance expressly states that in a "short-term treatment" scenario, "there may be only one timeframe for treatment goals."²² Notwithstanding CMS' clear direction in the interpretive guidance, many surveyors expect to see multiple short- and long-term goals, irrespective of the patient's expected length of stay. NABH submitted comments to CMS with respect to this B-tag,²³ cautioning

²⁰ Paul B. Lieberman et al., *Decreasing Length of Stay: Are There Effects on Outcomes of Psychiatric Hospitalization?*, American Journal of Psychiatry, Vol. 155, No. 7 (July 1998), <https://ajp.psychiatryonline.org/doi/full/10.1176/ajp.155.7.905>.

²¹ SOM App'x AA, cited above in note 17, Tag B118.

²² *Id.* Tag B121.

²³ Submitted November 19, 2018 in response to CMS-3346-P (RIN 0938-AT23).

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that, in a short-term stay, multiple highly specified goals can distract the team from focusing on the reasons for the patient’s admission or on how to assess readiness for discharge. This leads to treatment plans that focus on patient-identified goals such as “patient will focus on three new ways of coping with his boss” rather than more substantive movement toward discharge criteria.

Another surveyor practice that increases the paperwork burden is a rejection of 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, and so on.

Because of these B-tag interpretations, clinicians must spend time crafting highly tailored free-text plans and progress notes. Often, these documents must be written out by hand because many freestanding psychiatric hospitals do not have electronic health records (in part, because they were excluded from the \$38 billion Incentive Program

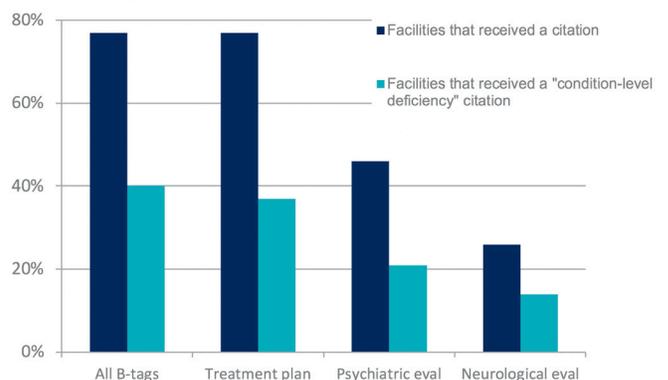
that CMS established in 2011). This approach is out of step not only with standard practice in non-psychiatric disciplines, but also with the medical industry’s trend toward appropriate use of check boxes and standardized language, which saves clinicians time and which (when contained in an electronic record) makes the data more searchable, analyzable, and portable.

The “Treatment Plan” Requirements are a Common Basis for Citations

No matter how much effort psychiatric facilities exert to ensure compliance with the B-tags, each survey may bring a new surveyor who may require modifications. Surveyors commonly find treatment plan processes and templates non-compliant even when they were reviewed without incident in prior surveys, or accepted in response to a corrective action plan. Each time a surveyor requires a change in the facility’s approach to, or documentation of, treatment plans, the facility must revise or write new policies, update its medical record templates, re-train its clinical and administrative staff (which may include hundreds of staff members), and conduct audits to ensure that the new policies are being followed.

If a surveyor identifies either a major issue or a number of minor issues, the facility will be cited for a “condition-level deficiency,” which puts the facility on a 90-day timeline for *termination from the Medicare program* unless the facility successfully implements a plan of correction. Regulators will assess the facility’s corrective actions at a 45-day follow-up survey (and, if that survey is unsuccessful, at a second follow-up survey before the 90-day termination deadline). Those follow-ups may be conducted by different surveyors, who may find yet more issues to cite.

Figure 3. Citations received by freestanding psychiatric facilities in the past two years



These problems appear to be especially pronounced in freestanding psychiatric hospitals, which receive B-tag compliance surveys that can last for two or three days. By contrast, psychiatric units are typically surveyed as part of the general hospital's overall compliance review, and may receive only a few hours of focused scrutiny. The extended survey time may help to explain why, among our respondents, almost 80 percent of freestanding psychiatric hospitals reported at least one citation related to treatment plans in their three most recent compliance surveys, compared to 36 percent of psychiatric units in general hospitals. Psychiatric hospitals were also more than twice as likely to be cited for a condition-level deficiency related to a treatment plan B-tag compared to psychiatric units (40 percent vs. 18 percent).

It bears emphasizing that citations related to the treatment plan typically focus on the facility's format for *documenting care*; oftentimes, the surveyors have no complaints about the way care is actually *delivered*. In these scenarios, all the money and time spent updating forms and re-training staff divert limited resources from providing high-quality care. The \$200 million that America's psychiatric facilities spend every year attempting to comply with the treatment plan B-tags could be spent on care improvement initiatives.

Case Study: Six Months Under the Microscope

One freestanding psychiatric hospital described a six-month period of non-stop surveys. Every surveyor seemed to apply a different interpretation of the B-tag requirements, leaving administrative and clinical staff scrambling to implement one redesign after another to avoid termination from the Medicare program. Nearly all of the citations related to care *documentation* rather than *quality or safety*; in fact, several surveyors praised the facility for its high quality of care.

Month 1. A TJC accreditation survey resulted in multiple B-tag citations related to documentation of psychiatric evaluations and treatment plans, including a treatment plan policy that had been specifically *requested* by a prior surveyor. The facility revised its documentation procedures in anticipation of a TJC follow-up survey within 45 days.

Month 2. CMS conducted a "validation" survey to confirm whether CMS agreed with TJC's findings. CMS identified B-tag deficiencies mostly relating to treatment plan documentation, including new issues that were not among TJC's original citations.

Month 3. TJC conducted its follow-up survey and found the facility compliant on all B-tags.

Month 4. During CMS' follow-up survey, the surveyor sought to impose several documentation policies that were not expressly mandated under CMS' rules or

guidance. The facility's staff pushed back—they were, by now, well-versed in B-tag requirements, and were exhausted and frustrated from all the changes they had already made—and the surveyor relented, eventually issuing a finding of compliance.

Month 5. A patient committed suicide (a "sentinel event"), which prompted an additional CMS survey. The facility had already conducted an internal review in response to the tragedy. It found no obvious shortcomings in existing policies or staff compliance, but the facility nonetheless implemented enhanced suicide prevention policies.

The CMS surveyors issued two citations, both based on documentation issues, which the surveyors deemed to constitute immediate jeopardy (IJ). Facilities must remedy IJ-level citations within 23 days. The surveyors required new policies, EHR updates, and staff re-trainings, which left the staff doubly demoralized; not only were they still grieving the loss of a patient, but they now had to revise all the policies and templates they had just finished implementing, policies and templates that had, mere weeks earlier, received certifications of compliance from both TJC and CMS.

Staff Qualifications: Surveyors Emphasize Credentials Over Competence

Several B-tags require psychiatric facilities to appoint various “director”-level positions.²⁴ We focus here on the 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.”²⁵ Even though CMS regulations allow for a nursing director who is “qualified by education and experience,” some 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 in Nurse Administration and more than *three decades* of work experience in psychiatric settings, plus certifications and continuing education coursework germane to psychiatric care. (The surveyor agreed not to issue a citation if the nursing director completed an additional seven hours of “continuing education” coursework *that same day*.)

This approach is at odds with present-day realities in two respects. First, candidates with a master’s degree in psychiatric nursing are in short supply. Many individuals who possess such a degree go on to become advanced practice clinicians rather than hospital administrators. 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 like hospital management or business administration.

Among facilities that reported a need to change their nursing director staffing practices because of this surveyor interpretation, the average additional cost of compliance amounts to more than \$600 *per day* for a 100-bed facility.

With respect to the corresponding B-tag requirement for the director of social services, the same facility would spend another \$420 per day.

A similar problem arises in another area of the B-tags. Upon admission, each patient must receive a psychiatric evaluation.²⁶ Some surveyors require that this evaluation be conducted by a *psychiatrist*, even if an APC—such as an NP or physician assistant—is licensed under state law to conduct such evaluations. Among facilities that have made staffing changes to ensure that psychiatrists are available for these evaluations, the average costs amount to more than \$1,000 per day for a 100-bed facility.

B-tags: Proposals for Reform

Many in the industry believe that the B-tag requirements are no longer appropriate in today’s environment of care, and should be eliminated wholesale. As part of CMS’ “Patients Over Paperwork” initiative, the agency proposed in September 2018 to permit non-physician clinicians to record progress notes, and invited recommendations for other ways to minimize provider burden with respect to the B-tags.²⁷ CMS should take this opportunity to modernize the regulations and the interpretive guidance to reflect modern methods of psychiatric care delivery, and, more generally, to allow psychiatric facilities the same flexibility afforded to hospitals under the general hospital CoPs. We recommend that CMS take the following steps.

- Convene a commission (with representation from inpatient psychiatric providers) to determine whether these psychiatric hospital CoPs remain relevant, and whether some—or all—of them should be revised or discarded.
- Emphasize to surveyors that psychiatric facilities—like general hospitals—may achieve compliance by adopting reasonable approaches to treatment plans, progress notes, and patient evaluations that is appropriate for the facility’s patient populations and operations. CMS can do so in the interpretive guidance itself, as well as in surveyor training materials.

²⁴ SOM App’x AA, cited above in note 17, Tags B141 & B143 (director of inpatient psychiatric services), B146–48 (director of nursing), B152 & B154 (director of social services), B158 (director of therapeutic activities).

²⁵ 42 C.F.R. § 482.62(d)(1).

²⁶ *Id.* § 482.61(b); SOM App’x AA, cited above in note 17, Tag B110.

²⁷ CMS, Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction, 83 Fed. Reg. 47686, 47703–04 (Sept. 20, 2018).

- Revise the regulations and B-tags addressing treatment plans, progress notes, and patient evaluation requirements (Tags B104 through B132) to be less prescriptive. Areas of particular concern to psychiatric facilities include the following:
 - The precise components of patient evaluations should be determined by psychiatric providers, not prescribed through B-tag survey “probe” questions. There are many clinically appropriate approaches to psychiatric and neurological evaluations; the degree of prescriptiveness in the B-tag guidance constrains professional judgment.
 - Providers should not be required to:
 - Identify in advance each member of a patient’s treatment team by name and discipline;
 - Include “individualized” descriptions for every clinician’s role and every treatment at every stage; or
 - Document “assets and deficits” or short- and long-term goals for all patients using specific formats, irrespective of the nature of the patient’s condition or the patient’s expected length of stay.
- Underscore to surveyors that a director-level positions may be designated based on competence in lieu of a specialized master’s degree, consistent with the CMS rule (Tags B147 (director of nursing), B154 (director of social services)).
- Clarify that facilities may, if desired, rely on APCs to conduct psychiatric evaluations, subject to applicable state licensure laws that define clinical scope of practice (Tag B110).

LIGATURE RISK

Similar to the preceding section, this section addresses the Medicare CoPs. We focus here on the CoP requiring all hospitals to provide care “in a safe setting.”²⁸ After a five-year period in which TJC received notice of 85 patient suicides in hospital environments,²⁹ CMS announced in 2017 that this “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.³⁰ Ligature points may include hand rails, door knobs and hinges, shower curtain rods, exposed plumbing or pipes, soap and paper towel dispensers, and ceiling projections such as light fixtures or sprinkler heads; potential ligatures include call bell cords and medical equipment power cords.

Quick Facts

Regulatory Burden: Ligature Risk

| | |
|---|-----------------|
| Estimated national annual costs (millions) | \$880.4 |
| Average cost per day for a 100-bed facility | \$3,462 |
| Average cost as a percentage of all-payer revenue for inpatient psychiatric services | 2.5% |
| Cost per licensed psychiatric bed: | |
| • Most recent complete fiscal year | \$9,422 |
| • Estimated spending on physical plant and equipment over the last 5 years and projected next fiscal year | \$15,590 |
| Percentage of facilities that were cited on a ligature issue in the last two years | 61% |
| Among cited facilities, percentage receiving an IJ citation | 14% |

CMS’ guidance acknowledges that it is unrealistic to expect any environment to be completely ligature-free, and so directs inpatient psychiatric facilities to maintain “ligature-resistant” spaces. Facilities are expected to screen patients for suicide risk and place high-risk patients in locations that are either (1) physically designed to be ligature-resistant, or

(2) under supervision with continuous 1:1 monitoring (i.e. one staff member assigned to monitor a single patient). CMS has promised more detailed guidance in the future, likely based on recommendations issued in 2017 by an expert panel that included representation from both CMS and TJC.³¹

The expert panel was convened based on a recognition that “surveyors for The Joint Commission and/or state agencies have disagreed on what constitutes a ligature risk and what mitigation strategies are acceptable.”³² Even with the benefit of the panel’s recommendations, however, surveyors continue to vary widely in their determination of what constitutes a ligature risk, and also as to the minimally acceptable remediation measures. Some surveyors appear to be unofficially enforcing a “ligature-free” standard, notwithstanding CMS’ recognition that such a standard is infeasible, and that monitoring can mitigate the presence of physical ligature risk points. To comply with this standard, a 100-bed psychiatric facility may spend more than \$3,400 per licensed psychiatric bed per day. That amounts to an estimated nationwide compliance burden of \$880 million per year.

Surveyors Demand High-Cost, Low-Value Renovations on Tight Timelines

One of healthcare providers’ primary goals is to assure the safety and well-being of all their patients. They do not always succeed, however. Even when patients receive the best care available—with the best facility design and the best equipment—sometimes their conditions prove fatal. That sad fact is as true of mental health conditions as it is of medical illnesses, such as heart failure or cancer. Recent efforts by CMS and TJC have no doubt contributed to safer patient environments, but there is a limit to what providers can realistically achieve. Moreover, incremental steps toward a fully ligature-free environment sometimes come with costs for patient care. Certain modifications demanded

²⁸ 42 C.F.R. § 482.13 (c)(2).

²⁹ The Joint Commission, *Special Report: Suicide Prevention in Health Care Settings*, Perspectives (Nov. 2017) [hereinafter “TJC Special Report”], https://www.jointcommission.org/assets/1/6/November_Perspectives_Suicide_Risk_Reduction.pdf.

³⁰ CMS, *Clarification of Ligature Risk Policy*, S&C Memo 18-06-Hospitals (Dec. 8, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-06.pdf>.

³¹ CMS, *CMS Clarification of Psychiatric Environmental Risks*, QSO 18-21-All Hospitals (July 20, 2018), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-21-Hospitals.pdf>.

³² TJC Special Report, cited above in note 29.

by surveyors, such as mandatory paper gowns, removal of bathroom doors, and increased monitoring are not only unnecessary for many patients, but may undermine patient dignity and actually impede patient recovery.

Even when a psychiatric facility makes ligature-related modifications that one set of surveyors recommends, new surveyors may soon come along requesting a new set of changes, sometimes to the very same equipment that the facility recently finished replacing. In some cases, surveyors require changes that provide, at most, a marginal improvement over existing infrastructure, rather than evaluating whether the provider's approach is reasonable based on the facility's patient population and track record of preventing patient suicide attempts. Some demands do not appear to be supported by empirical evidence, and seem to reflect the surveyor's personal opinion. (See the case study call-out boxes for additional examples.)

Among our respondents who reported on survey activity over the last two years, 60 percent received a ligature-related citation. An additional factor that makes these problems all the more acute is that surveyors are increasingly citing ligature risk issues at the "immediate jeopardy" (IJ) level of severity, which puts the facility on an expedited timeline (23 days) to make the necessary changes or be terminated from the Medicare program. (Extensions of time may be granted in special cases, such as when a facility must implement major physical plant renovations.)

If the facility can successfully remediate an IJ citation while the surveyor is still on site, the surveyor may reduce the citation to a condition-level deficiency (with a 90-day termination timeline). Even with that opportunity for on-site remediation, however, IJ citations accounted for almost 15 percent of the ligature-related citations issued to our respondents over the last two years.

Case Studies: Medical Beds

Hospital medical beds (often called "med beds") have handrails along the sides, and can be raised, lowered, and adjusted in other ways to accommodate frail patients who have trouble getting in and out of bed, or who, for medical reasons, need to lie in particular positions.

One psychiatric hospital purchased med beds that were specifically designed for the behavioral health context. These beds came at a cost of \$10,000 to \$12,000 a piece, and were considered an industry standard. A surveyor nonetheless cited the beds as a ligature risk, even after conceding that *all* beds of this type present a certain degree of ligature risk. The facility's clinical staff explained that certain patients' medical conditions made the use of med beds important for health and safety. In response, the surveyor permitted use of a med bed only if a doctor ordered the bed as medically necessary *and recertified the order every 24 hours*, even for chronic conditions that do not change day-to-day (such as aspiration issues or fall concerns). Thus, to preserve the standard of care, clinicians took on yet another documentation burden. In addition, the facility took on the physical burden of storing unneeded platform beds on site.

Another facility with a geriatric unit encountered a similar issue, but with even higher stakes: the surveyor there threatened to issue an "immediate jeopardy"

citation unless the facility acquired at least one platform bed *before the end of the survey*. As in the prior example, the surveyor permitted the use of a med bed if ordered by a physician as medically necessary, but this surveyor went a step further and required continuous 1:1 monitoring for each and every med bed.

Case Study: More Monitoring

A surveyor (who had no background in behavioral health) visited a facility that had operated for more than a decade without a single patient suicide. The surveyor cited the facility for having an insufficient number of patients on 1:1 continuous monitoring. When questioned, the surveyor would not—or could not—specify the number of additional patients who should receive monitoring, or even identify specific patients then at the facility who should have been monitored. He merely stated his view that *more* patients should be on 1:1 monitoring. A psychiatrist at the facility developed an algorithm that would automatically assign patients to 1:1 monitoring based on criteria pulled from the admission screening (even though, in the psychiatrist's professional view, many of those additional patients were not appropriate candidates for monitoring). The facility then took on the expense of creating a pool of on-call staff available for the additional monitoring duties.

These practices produce much wasted time and money as facilities swap out one surveyor-approved design for another. In addition, renovations tend to be more costly when they must be rushed to satisfy a surveyor-imposed deadline. Over the prior five years and including the current fiscal year, our respondent facilities estimate spending an average of more than \$12,700 *per psychiatric bed* on physical plant renovations and equipment purchases specifically related to mitigating ligature risk. Some facilities were much harder hit: five facilities in our survey reported five-year costs in excess of \$50,000 per bed, reaching as high as \$127,000 per bed.

These striking numbers still do not tell the complete story. Required renovations may put patient beds out of commission, which causes additional ripple effects. One respondent facility received four ligature-related citations relating to toilet seats, toilet paper dispensers, and door knobs on bedroom and closet doors. Many of these features had been specifically chosen with ligature risk in mind, but the surveyor was insistent. Over the next four months the facility spent more than \$750,000 in renovations, renovating eight rooms at a time, which reduced the facility's capacity by approximately 15 percent. Not only did the facility's lost revenue add to the financial burden of renovation costs, but the community suffered reduced access to inpatient psychiatric services until the renovations were complete.

“Surveyors hammer us on little things instead of working collaboratively with us. They seem more focused on catching us for something than on helping us improve.”

–Psychiatrist with an executive role at a freestanding psychiatric hospital

Ligature Risk: Proposals for Reform

CMS should issue its promised guidance as soon as possible to minimize wasteful renovations. In that guidance, CMS should endeavor to standardize survey practices, both across surveying bodies and among individual surveyors. We recommend that CMS take the following steps.

- Require surveyors to apply a more evidence-based approach to ligature-risk review. If the facility's current equipment, design, or practice is widely used and has not been linked to any known patient self-harm attempts

the facility's approach should be presumed compliant; surveyors should be required to offer an empirical basis for requiring a modification. Absent a compelling empirical basis for demanding immediate, large-scale changes, surveyors should be limited to, if anything, recommending modifications.

- Clarify that an inpatient psychiatric facility need not design highly ligature-resistant physical spaces in areas that are under constant supervision, such as nursing stations and cafeterias, unless there is a special need for such design.
- Identify areas of design or categories of equipment that carry particularly acute ligature risk, thereby putting inpatient psychiatric facilities on notice that those areas are likely to be closely scrutinized during surveys. If CMS later identifies additional areas of acute concern, the agency should issue a public notice so providers have a reasonable opportunity to implement any necessary changes before their next review. This policy would allow facilities to plan ahead and budget for the changes. Emergency renovations undermine efficiencies, heighten the risk that clinicians will need to refocus attention away from care delivery, and can create financial hardship for the facility.
- Minimize the risk of redundant renovations. After a surveyor accepts a particular design feature as ligature-resistant when approving a corrective action plan or during a validation survey, future surveyors should not be permitted to issue citations based on that approved feature for a prescribed period (e.g., three years), absent special circumstances.

THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

We turn now from the Medicare CoPs to EMTALA, a statute Congress passed in 1986 to address the problem of “patient dumping.”³³ As the House Committee on Ways and Means explained, Congress was responding to “the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance.”³⁴

Under EMTALA, a patient who presents to an emergency department (ED) must receive a medical screening exam performed by a “qualified medical person” (QMP). If the screening exam reveals an emergency medical condition, the hospital may not discharge or transfer the patient until the emergency condition has been stabilized, irrespective of the patient’s health coverage status or ability pay for care.³⁵

EMTALA’s requirements apply to any Medicare-participating hospital with a “dedicated emergency department,” which includes any psychiatric facility that offers “24-hour psychiatric services on a walk-in basis.”³⁶ If CMS determines that a provider has violated EMTALA, the agency may impose a fine of more than \$100,000 *per violation*. CMS may also terminate the provider from the Medicare program absent a demonstration that the provider has implemented policies to protect against future violations.

In recent years, some regulators have begun applying novel interpretations of EMTALA: first, raising the minimum qualifications for a QMP who performs emergency medical screenings of psychiatric patients, and second, requiring psychiatric facilities to admit patients who have been brought to the ED against their will. These expanded interpretations—which upend decades of accepted practice—are not documented in any written guidance.

Even without formal guidance, regulators have applied these interpretations often enough, and have secured settlements large enough,³⁷ that many psychiatric facilities have begun making preemptive changes at great cost, especially those providers in the geographic regions where regulators have been pursuing these interpretations most vigorously. Nationwide, these novel approaches to EMTALA cause inpatient psychiatric facilities to spend an estimated \$210 million every year.

Quick Facts

Regulatory Burden: EMTALA

| | |
|--|----------------|
| Estimated national annual costs (millions) | \$209.6 |
| Average cost per day for a 100-bed facility | \$824 |
| Average cost as a percentage of all-payer revenue for inpatient psychiatric services | 0.6% |
| Average annual cost per psychiatric bed | \$2,243 |

Surveyors Demand Advanced Licensure for Emergency Screenings

EMTALA allows each hospital and its medical staff to establish eligibility criteria for the QMPs who conduct emergency medical screenings.³⁸ Emergency medical screenings can take a variety of forms, as explained in CMS guidance: “Depending on the individual’s presenting signs and symptoms, an appropriate [medical screening exam] can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures.”³⁹

³³ CMS has defined a general hospital CoP relating to “emergency services,” which are assessed during standard hospital accreditation and validation surveys. 42 C.F.R. § 482.55. EMTALA defines a distinct set of obligations, which are codified separately from the CoPs. Id. § 489.24. EMTALA compliance is assessed during complaint-driven reviews rather than routine surveys, and violations of EMTALA are subject to monetary penalties that are not available for CoP deficiencies. 42 U.S.C. § 1395dd(d).

³⁴ H.R. Rep. 99-241 (Part I) (July 31, 1985).

³⁵ 42 U.S.C. § 1395dd; 42 C.F.R. § 489.24.

³⁶ Health Care Financing Admin. & OI), Medicare Program; Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32086, 32101 (June 22, 1994).

³⁷ See, for example, the case brought against AnMed Health, which settled for \$1.3 million dollars in June 2017. OIG, *Civil Monetary Penalties and Affirmative Exclusions*, <https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp> (last accessed Feb. 3, 2019). For more detail on this case and the background legal issues, see Robert Bitterman, *Federal Government Declares Emergency Physicians Incapable of Performing Medical Screening Exam for Psychiatric Patients in AnMed Lawsuit*, ACEP Now (Oct. 17, 2017), <https://www.acepnow.com/article/federal-government-declares-emergency-physicians-incapable-performing-medical-screening-exam-psychiatric-patients-anmed-lawsuit/>.

³⁸ 42 C.F.R. § 489.24(a)(i).

³⁹ CMS, SOM Appendix V, Tag A-2406/C-2406, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_V_emerg.pdf.

Each hospital's QMP criteria may take into account individual clinician experience and training in performing various types of emergency screenings, subject to state licensure laws that define the outer limits of each clinician's scope of practice. In many states, for example, nurse practitioners (NPs) are fully independent clinicians who are authorized to diagnose patients, consulting with specialists only as needed (as would a generalist physician).⁴⁰ Registered nurses (RNs) and licensed clinical social workers are often permitted to perform various types of preliminary "assessments," and then consult with a physician or other advanced clinician to establish a disposition and preliminary treatment plan.⁴¹ Many hospital EDs rely on some combination of NPs, RNs, and social workers to provide emergency medical screenings within their scope of practice. These clinicians may practice alongside ED physicians or psychiatrists, or may consult with physicians by telephone or telemedicine to confirm a disposition.

Now, however, some federal regulators are interpreting EMTALA in a manner that imposes baseline licensure requirements on QMPs who perform emergency *psychiatric* screenings, irrespective of other qualifications or experience:

- For acute care hospitals, regulators have required that the QMP be a psychiatrist rather than an ED physician or APC, such as an NP or physician assistant.

- For freestanding psychiatric hospitals, regulators have required that the QMP be an APC rather than a RN or master's-level social worker.

Congress passed EMTALA to ensure that all patients would receive a screening for emergency medical conditions by a qualified medical professional; Congress did not require that every patient receive a screening from a medical specialist. In an acute care hospital, ED physicians and APCs are considered competent to diagnose and stabilize a wide range of conditions. Hospitals need not bring in a cardiologist for every heart attack or a gastroenterologist for every case of appendicitis. And as noted above, many states also authorize RNs and social workers to conduct psychosocial assessments and other preliminary screenings.

Requiring a specific licensure level for QMPs is not only inconsistent with law, but also fails to recognize the growing shortages of psychiatrists and psych-specialized APCs, especially outside major urban centers. As of December 2017, an estimated 123 million Americans—nearly 40 percent of the population—lived in regions designated as "mental health professional shortage areas."⁴² Some facilities have tried to address this shortage by relying on tele-consultations with psychiatrists, but others have reported that regulators deem such consultations insufficient to satisfy EMTALA.

Case Study: The Million-Dollar Nurse

A freestanding psychiatric hospital had long maintained a policy of designating RNs as QMPs if they completed training conducted by the medical staff. These RNs conducted preliminary assessments (vital signs, systems review, and if appropriate, a breathalyzer test), then consulted with a physician by telephone to establish a disposition.

After years without incident, a CMS surveyor alleged that the facility used improper QMPs and issued an IJ determination. The surveyor initially demanded that

the facility maintain an on-site physician to conduct emergency screenings, but the facility protested that such a policy was neither legally required nor financially feasible. The CMS Regional Office ultimately agreed to deem the facility compliant if it embedded an NP in the intake department 24 hours a day to conduct emergency screenings. This staffing change—to use NPs instead of registered nurses for the emergency medical screening—came at an annual cost of more than \$1 million.

⁴⁰ American Ass'n of Nurse Practitioners, *State Practice Environment* (last updated Dec. 20, 2018), <https://www.aanp.org/advocacy/state/state-practice-environment>.

⁴¹ The Policy Surveillance Program, *Registered Nurse Scope of Practice*, LawAtlas (last updated Aug. 1, 2015), <http://lawatlas.org/datasets/registered-nurse-scope-of-practice-1509027306>; National Ass'n of Social Workers, *NASW Standards for Social Work Case Management* (2013), <https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0>.

⁴² Henry J. Kaiser Family Foundation, *Mental Health Care Health Professional Shortage Areas (HPSAs)*, <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas>.

Some facilities, such as large academic medical centers, may have sufficient numbers of psychiatrists or APCs that this requirement imposes no major hardship. Among facilities that modified their practices to satisfy this new EMTALA interpretation, however, the costs ranged as high as \$18,000 per 100 days of inpatient care.

“The QMP’s job is to perform an emergency screening, not to make a final diagnosis. This new approach is the equivalent of saying that a nurse can’t tell whether or not a pregnant woman is in labor.”

–Executive responsible for clinical services at multiple freestanding psychiatric hospitals

In sum, CMS’ new interpretation of EMTALA’s QMP requirement fails to respect the clear federal rule permitting each facility to designate QMPs within the limits set by state licensure laws; fails to accord parity to psychiatric and non-psychiatric emergency medical screenings; and fails to recognize the reality of psychiatric staffing shortages.

Requiring Psychiatric Facilities to Accept Involuntary Admissions

If a patient is found to present an immediate threat of harm to herself or to someone else, a psychiatric facility may admit the patient against her will under a process known as “involuntarily commitment.” Each state has its own legal process for certifying that a patient qualifies for temporary involuntary commitment, typically involving a one or more medical determinations, and often an emergency order from a judge.⁴³ These rules exist to protect citizens against deprivations of their liberty without due process of law.

Involuntarily admitted patients require different treatment protocols than voluntary admissions, and may also pose a heightened risk to staff and other patients.⁴⁴ Recognizing this fact, some states maintain networks of state-run and state-contracted facilities that specialize in treating this patient population. The number of facilities able to accept involuntarily committed patients has diminished sharply with the closure of many state psychiatric facilities, as described above in the introduction.

Some psychiatric facilities are not able to accept involuntary admissions—at certain times, or at all—due to lack of beds, lack of staff, or other concerns. If a patient is brought involuntarily and refuses consent for a voluntary admission, the facility may keep the patient in the ED until the patient can be safely transferred to a designated facility for involuntary commitment. In some communities, psychiatric facilities have standing transfer agreements with the state government and nearby designated facilities, but often beds at these facilities are not immediately available.

Some regulators from CMS and OIG have begun using the threat of EMTALA citations to push back against this long-established practice of keeping a patient in the ED until a more appropriate facility has a bed available. These regulators assert that facilities fail in their duty to “stabilize” a patient if the patient remains too long in the ED. Their interpretation appears to be that *any psychiatric facility with an ED*—including a facility that accepts 24/7 walk-ins—must admit a patient involuntarily if (1) the patient qualifies for involuntary commitment and (2) the facility has any psychiatric inpatient beds available.

This interpretation is arguably inconsistent with EMTALA itself, as some legal experts have asserted.⁴⁵ Whether or not CMS and OIG are acting beyond their legal authority, however, respondents in our survey expressed grave concerns that regulators’ actions are endangering both

⁴³ Treatment Advocacy Center, *State Standards for Initiating Involuntary Treatment* (last updated July 2018), <https://www.treatmentadvocacycenter.org/storage/documents/state-standards/state-standards-for-initiating-involuntary-treatment.pdf> (describing each state’s legal procedures); Treatment Advocacy Center, *Emergency Hospitalization for Evaluation Assisted Psychiatric Treatment Standards by State* (last updated June 2011), https://www.treatmentadvocacycenter.org/storage/documents/Emergency_Hospitalization_for_Evaluation.pdf (describing each state’s standard for determining whether an individual qualifies for involuntary commitment).

⁴⁴ A systematic meta-analysis concluded that “the proportion of involuntary patients admitted under provisions of mental health laws is associated with the overall proportion of inpatient violence,” while recognizing that “the association between involuntary admission and violence is also likely to be complex”:

First, evidence that a person is a danger to themselves or to others is a requirement for involuntary admission in many jurisdictions, creating a high threshold for treatment and, in effect, selecting patients who have been violent or who appear very likely to commit an act of violence. Moreover, the process of involuntary admission and detention in a locked ward can amplify the patient’s hostility and propensity to violence, especially if they do not recognize the need for treatment.

Laura Iozzino et al., *Prevalence and Risk Factors of Violence by Psychiatric Acute Inpatients: A Systematic Review and Meta-Analysis*, *PLoS ONE* 10(6): e0128536 (June 10, 2015), <https://doi.org/10.1371/journal.pone.0128536>.

⁴⁵ See, for example, the position taken in Bitterman, *Federal Government Declares Emergency Physicians Incapable of Performing Medical Screening Exam for Psychiatric Patients in AnMed Lawsuit*, cited above in note 37.

psychiatric patients and clinical staff. Regulators have demanded that facilities admit patients against their will whether or not the facility is designated under state law to receive involuntarily admissions; whether or not the facility has standing transfer agreements in place with facilities that *are* designated; and whether or not the facility has adequate staff on-site for the heightened treatment and security needs that come with admitting patients against their will.

Some inpatient psychiatric units are designated for particular patient populations, such as geriatric or adolescent patients, anorexic or depressive patients. Admitting a patient with violent tendencies—against his or her will—to the same inpatient unit may jeopardize the safety of the facility’s other patients and the staff that cares for them, and may also compromise other patients’ treatment and progress. Moreover, these specialized units may not be the most appropriate setting for an involuntarily committed patient, who may benefit most from a different care environment designed for different therapeutic interventions.

Among our respondents that sought to achieve compliance with this new interpretation of EMTALA by regulators, the average annual cost was approximately \$1,250 per inpatient psychiatric bed. Some facilities, however, viewed the cost as too great, both in terms of the finances and in terms of the risk to their patients and staff. In response, some facilities have sought to avoid the application of EMTALA by no longer taking walk-ins late at night. In such cases, the entire community suffers reduced access to care.

Everyone deserves access to safe and effective care. That includes individuals whose mental health conditions grow so severe that they qualify for temporary involuntary commitment. Unfortunately, access to psychiatric care is currently limited—for these individuals and others—by systemic factors such as a shortage of psychiatric beds (especially in facilities that are equipped to accept involuntary admissions), a shortage of psychiatrists and APCs, and inadequate reimbursement dollars for psychiatric services (especially for individuals with other health-risk factors like low income, homelessness, and social isolation). These are real problems, but EMTALA cannot solve them, however broadly the law is interpreted. This approach fails to meaningfully engage with the drivers of inadequate access, and may actually increase the facilities’ costs to the point that facilities may choose to shut their doors entirely.

EMTALA: Proposals for Reform

Some regulators are stretching EMTALA to achieve ends beyond the statute’s proper scope. CMS and OIG should ensure that regulators are enforcing the statute, the regulations, and the agencies’ own guidance as written, especially with respect to the following topics.

First, as in general hospitals, psychiatric facilities and their medical staffs should be permitted to designate QMPs based on qualifications and competence, up to the limit of each clinician’s scope of practice as defined under state law. If a facility deems an ED physician or RN qualified to serve as a QMP, surveyors should respect that determination, absent evidence of patient harm or a violation of law.

Second, EMTALA should not be used to address the shortage of facilities that treat involuntary committed patients. Federal regulators should respect state procedures for involuntary commitment, including state arrangements for facility designation and patient transfer. Regulators should not use the threat of EMTALA sanctions to force all psychiatric facilities with an ED to accept involuntary admissions, especially at the potential expense of the *voluntarily* admitted patients’ safety and treatment.

CONCLUSION

This report has highlighted several federal regulatory requirements that impose heavy compliance costs on inpatient psychiatric facilities without providing any comparable benefits to the patients they serve. These burdens may arise from outdated regulations, unduly prescriptive guidance, or variability among surveyors.

Together, these factors amount to an estimated annual \$1.7 billion in compliance costs for America's inpatient psychiatric facilities, just under \$1 million on average per inpatient psychiatric facility nationwide. Every dollar spent on compliance, however, is a dollar that could be used to improve quality or expanding access to psychiatric care. Of course, certain current regulatory requirements directly *distract* from patient care, especially those that force clinicians to spend their time on endless documentation instead of care delivery.

These concerns lie at the heart of CMS' "Patients Over Paperwork" initiative. CMS should take this opportunity to modernize its guidance and standardize its survey practices. This report does not purport to offer a panacea for all that ails the nation's behavioral healthcare infrastructure, but the proposals outlined here would cost CMS little to implement, and would lift a heavy burden from psychiatric facilities and their staff without affecting—and perhaps even improving—care quality and access for patients with severe behavioral healthcare needs.

GLOSSARY: ACRONYMS AND KEY TERMS

| | |
|---|--|
| APC | Advanced practice clinician, such as a nurse practitioner or physician assistant |
| B-tags | Individual compliance elements defined in CMS interpretive guidance with respect to the Medicare conditions of participation for psychiatric hospitals |
| CMS | The Centers for Medicare & Medicaid Services |
| Condition-level deficiency | A lower level of citation severity than “immediate jeopardy.” Condition-level deficiencies must be remedied within 90 days. |
| CoPs | Conditions of participation for providers in the Medicare program |
| ED | Emergency department |
| EMTALA | The Emergency Medical Treatment & Labor Act |
| HHS | The U.S. Department of Health & Human Services |
| IJ/Immediate Jeopardy | The most severe level of citation. IJ citations must generally be remedied within 23 days (contrast with “condition-level deficiency”). |
| Inpatient psychiatric facilities | Freestanding psychiatric hospitals and general acute care hospitals with inpatient psychiatric units. This term does not include long-term residential facilities. |
| Ligature risk point | A location where a patient might attach a cord-like object for the purpose of hanging or self-strangulation |
| NABH | The National Association for Behavioral Healthcare |
| NP | Nurse practitioner |
| OIG | The Office of Inspector General of the U.S. Department of Health & Human Services |
| Psychiatric facilities | See “inpatient psychiatric facilities,” above |
| QMP | A “qualified medical person” who performs emergency medical screenings pursuant to EMTALA |
| RN | Registered nurse |
| TJC | The Joint Commission, a private accreditation organization for psychiatric facilities |

APPENDIX A: SURVEY AND QUANTITATIVE ESTIMATION METHODOLOGY

The quantitative estimates of regulatory burden compliance costs and citation experience included in this paper are derived from the results of a hospital regulatory burden survey, combined with data from hospital cost reports and other sources to derive national estimates of compliance cost. Details on the survey design and estimation methodology are provided below.

Psychiatric Hospital Regulatory Burden Survey

Estimates of the frequency of citations and compliance costs associated with the three regulatory areas discussed in this report were derived from a survey of NABH-member hospital systems. The regulatory burden survey was conducted by Manatt Health in January and February of 2019. Seventeen distinct hospital systems around the country provided responses to the survey, reporting data for a total of 62 individual inpatient psychiatric facilities. The response rate among health systems surveyed was 63 percent.

Regulatory Burden Survey Sampling and Respondent Demographics

Health systems operating one or more inpatient psychiatric facilities were surveyed from within the NABH membership. To ensure representation of different types of psychiatric hospitals and systems across the country, sampling of inpatient psychiatric hospitals was stratified by three demographic features:

- Hospital type: Freestanding psychiatric hospitals vs. general acute care hospitals with psychiatric units;
- System size: Independent/small health systems with <20 facilities vs. large health systems with ≥20 facilities; and
- Census geographic region (Northeast, Midwest, South, West).

Facility responses were distributed within this sampling matrix as follows:

Table A-1: NABH Regulatory Burden Survey - Facility Response Counts by Facility Demographic Segmentation

| Inpatient Psychiatric Facility Demographic Segment | Census Region | | | | Total |
|--|---------------|-----------|-----------|-----------|-----------|
| | Midwest | Northeast | South | West | |
| Freestanding Psychiatric Hospital | 6 | 10 | 10 | 12 | 38 |
| Independent/Small System <20 Facilities | 2 | 5 | 6 | 7 | 20 |
| Large System ≥20 Facilities | 4 | 5 | 4 | 5 | 18 |
| | | | | | |
| General Acute Care Hospital | 3 | 11 | 8 | 2 | 24 |
| Independent/Small System <20 Facilities | 2 | 9 | 0 | 2 | 13 |
| Large System ≥20 Facilities | 1 | 2 | 8 | 0 | 11 |
| | | | | | |
| All Inpatient Psychiatric Hospitals | 9 | 21 | 19 | 14 | 62 |
| Independent/Small System <20 Facilities | 4 | 14 | 6 | 9 | 33 |
| Large System ≥20 Facilities | 5 | 7 | 12 | 5 | 29 |

National regulatory burden compliance cost estimates were based on reported facility compliance cost data segmented by inpatient psychiatric hospital facility type. Due to differential response rates, several of the strata in the initial sampling design received an inadequate number of facility responses to generate appropriate estimates of variation by region and health system size.

Regulatory Burden Survey Instrument

The regulatory burden survey contained a series of questions designed to collect information about facilities’ quantitative and qualitative experiences of regulatory compliance burden with regard to three distinct regulatory domains: B-tags, Ligature Risk, and EMTALA. Within each of these domains, respondents were asked to provide information specific to each of a series of more specific regulatory sub-topics. In total, respondents were asked to provide information on ten distinct regulatory issues:

Table A-2: Regulatory Burden Topics Included in Survey

| Regulatory Domain | Regulatory Topic |
|--------------------------|---|
| B-tags | B1 – Treatment Plans |
| B-tags | B2a – Minimum Qualifications - Director of Inpatient Psychiatric Services |
| B-tags | B2b – Minimum Qualifications - Director of Psychiatric Nursing Services |
| B-tags | B2c – Minimum Qualifications - Director of Social Services |
| B-tags | B3 – Psychiatric Evaluations |
| B-tags | B4 – Neurological Screenings |
| Ligature Risk | L1 – Physical Environment |
| Ligature Risk | L2 – 1:1 Monitoring |
| EMTALA | E1 – Emergency Medical Screenings |
| EMTALA | E2 – Involuntary Admissions |

For each regulatory issue, respondents were asked to report their compliance costs in three categories (physical plant and equipment costs, clinical staff costs, and other costs), for four distinct timeframes (most recent complete fiscal year, previous two fiscal years, previous five fiscal years, and projected costs for the current/upcoming fiscal year). Respondents were specifically instructed to report only the incremental costs that they considered new expenses incurred as a direct result of recent changes in the regulatory environment; in cases where a facility has consistently met or exceeded a given regulatory requirement and did not incur new costs, they were instructed to report zero for the topic in question.

In addition, for each regulatory issue, respondents were asked about their experience with regard to surveys and citations by accreditation organizations (such as TJC) or by federal or state agencies. Respondents were asked

to report the number of survey events and citations they received in the last two complete fiscal years (for EMTALA and Ligature Risk) or their three most recent surveys (for B-tags). In addition, respondents were asked to identify how many of the citations they received were “immediate jeopardy”-level (for EMTALA and Ligature Risk) or condition-level (for B-tags). As part of their survey response, respondents were also given the opportunity to provide additional information or commentary on their survey and citation experience, or the regulatory topics more generally.

Finally, facilities were also asked to provide basic demographic information, including the number of psychiatric staffed beds, psychiatric utilization days, psychiatric utilization discharges. This data was used to produce per psychiatric inpatient day and per psychiatric staffed bed cost metrics.

Estimation of Citation Rates Among Surveyed Facilities

Forty-six of 62 total facilities surveyed (74 percent) provided information on their citation experiences in one or more regulatory domains. Citation rates (any citation experience, or immediate jeopardy/condition-level deficiency citation experience) for each regulatory domain are calculated as the number of reported citations divided by the number of facilities providing survey information across all domains. Immediate jeopardy/condition level deficiency citation experience was calculated as a share of citations received, per regulatory issue.

Estimation of Regulatory Burden Compliance Costs Among Surveyed Facilities

Survey data was used to derive estimates of annual and five-year compliance cost for each of the regulatory issues included in the study, on a per-day and per-staffed-bed basis. Inpatient psychiatric days and staffed psychiatric beds were identified based on the responses each respondent provided on the facility demographic measures. In a small number of cases, psychiatric days were imputed based on reported psychiatric bed count, assuming full occupancy to derive a conservative cost per day.

When calculating overall compliance cost per facility or per bed, facilities were included in all calculations for a specific issue and time period unless they specifically noted in their survey response that the item was not applicable to them, or that they were unable to report or did not have data available to respond on a specific question. Additional cost per day and cost per bed metrics were reported only for facilities with a non-zero compliance cost on a given issue, which is particularly salient for issues that impact a relatively small share of facilities but may have a significant cost for those facilities that are impacted.

Annual cost metrics were calculated using the sum of all three cost categories (physical plant and equipment, clinical staff, and other costs) for the most recent complete fiscal year time period. In some cases, a single cost category was reported separately, for example physical plant and equipment costs were specifically reported with regard to the physical environment issue in the Ligature Risk domain discussion. Annual per-day metrics were calculated as a

cost per reported psychiatric day for the most recent fiscal year. Annual per-bed metrics were calculated as a cost per reported staffed psychiatric bed.

With regard to physical environment, five-year physical plant and equipment costs per bed were also reported. Five-year cost metrics were calculated as the sum of two reported time periods: the five-year (or longest) prior time period reported by the facility, and the projected next fiscal year period. Many facilities (35 percent) reported single-year or two-year blended costs on this measure, but were unable to report a comprehensive five-year cost. In these cases, the greater of the two (single-year or two-year blended cost) was imputed as the five-year cost, yielding a conservative estimate of the true five-year cost. One facility response was excluded from the calculation of five-year physical-environment-related costs as an extreme high outlier.

National Estimates of Regulatory Compliance Costs

Manatt utilized data from the 2016 CMS Hospital Cost Report (HCRIS) public use files to identify the universe and characteristics of inpatient psychiatric facilities nationwide. This data was then used in combination with the regulatory burden survey results to generate appropriate weighted estimates of the national regulatory compliance cost associated with each of the regulatory issues discussed in this report.

Psychiatric Hospital Identification and National Demographics

Two categories of inpatient psychiatric facilities—freestanding psychiatric hospitals and general acute hospitals with inpatient psychiatric sub-provider units—were identified using data from HCRIS Worksheet S-2. Inpatient psychiatric hospitals were identified as any hospital with a provider number between xx.4000 and xx.4499. General acute hospitals with inpatient psychiatric sub-provider units were identified as any other hospital type with a sub-provider unit reported where the sub-unit CCN identifier had a third digit of “S” or “M”, or was coded as provider type 4. In total, 1,738 inpatient psychiatric facilities (580 freestanding psychiatric hospitals and 1,158 general acute hospitals) were identified using this method.⁴⁶

⁴⁶ At the time of this writing, 2016 HCRIS reporting was mostly complete. Each year, however, individual facilities may submit late cost reports, and so HCRIS data can evolve over multiple years. As such, the number of identified facilities may be slightly lower than the actual number of psychiatric facilities operating nationwide, yielding slightly conservative estimates of national regulatory burden costs.

For the facilities identified, key demographic metrics were gathered from HCRIS Worksheet S-3. Specifically, HCRIS data was used to identify the number of licensed inpatient psychiatric beds and bed days. Psychiatric beds/days were defined as the total inpatient beds/days for freestanding psychiatric facilities, or psychiatric subunit beds/days for general acute facilities.⁴⁷ In addition, facility net patient service revenue and operating margins were calculated using data from Worksheet G-3.

National inpatient psychiatric facility demographics compared to survey respondent demographics are identified in the table below. As discussed below, national cost estimates were calculated on a cost per day basis, weighted by facility type.

Psychiatric Inpatient National Compliance Cost Estimates

As discussed above, annual per-day cost metrics calculated from the NABH regulatory burden survey were combined with national counts of inpatient psychiatric bed days to calculate annual national compliance cost estimates. Calculated cost per day for the most recent fiscal year was calculated from the survey data for each regulatory issue, inclusive of all facilities with valid survey responses for the regulatory issue in question. The annual per-day cost observed in the survey for each regulatory issue were then multiplied by the national total inpatient days for the 1,738 inpatient psychiatric facilities identified in the HCRIS data, segmented by inpatient hospital type (freestanding

Table A-3: National Inpatient Psychiatric Hospital Demographics by Type/Region, with NABH Regulatory Burden Survey Comparison

| Facility Type/Region | National Inpatient Psychiatric Hospitals (2016 HCRIS) | | | | NABH Regulatory Burden Survey Respondents | | | |
|---------------------------------------|---|---------------------|----------------------|--|---|--------------------|----------------------|--|
| | Facility Demographic Counts | | | Regional Share of Psych Inpatient Days | Facility Demographic Counts | | | Regional Share of Psych Inpatient Days |
| | Psych Hospital Facilities | Licensed Psych Beds | Psych Inpatient Days | | Psych Hospital Facilities | Staffed Psych Beds | Psych Inpatient Days | |
| General Acute Care Hospital | 1,158 | 35,148 | 9,060,279 | | 23 | 939 | 253,917 | |
| Midwest | 293 | 7,514 | 1,850,039 | 20.4% | 3 | 245 | 70,936 | 27.9% |
| Northeast | 260 | 10,353 | 2,981,979 | 32.9% | 10 | 315 | 94,953 | 37.4% |
| South | 450 | 12,395 | 2,973,149 | 32.8% | 8 | 321 | 69,354 | 27.3% |
| West | 152 | 4,778 | 1,223,772 | 13.5% | 2 | 58 | 18,674 | 7.4% |
| Other/Unknown | 3 | 108 | 31,340 | 0.3% | 0 | 0 | 0 | 0.0% |
| Freestanding Psychiatric Hosp. | 580 | 58,296 | 16,370,888 | | 39 | 4,961 | 1,301,885 | |
| Midwest | 130 | 10,783 | 3,071,935 | 18.8% | 7 | 782 | 214,565 | 16.5% |
| Northeast | 99 | 13,416 | 4,125,092 | 25.2% | 10 | 1,124 | 322,583 | 24.8% |
| South | 247 | 22,549 | 6,051,867 | 37.0% | 10 | 1,498 | 398,066 | 30.6% |
| West | 99 | 11,053 | 2,982,857 | 18.2% | 12 | 1,557 | 366,671 | 28.2% |
| Other/Unknown | 5 | 495 | 139,137 | 0.8% | 0 | 0 | 0 | 0.0% |
| Total Psychiatric Hospitals | 1,738 | 93,444 | 25,431,167 | | 62 | 5,900 | 1,555,802 | |
| Midwest | 423 | 18,297 | 4,921,974 | 19.4% | 10 | 1,027 | 285,501 | 18.4% |
| Northeast | 359 | 23,769 | 7,107,071 | 27.9% | 20 | 1,439 | 417,536 | 26.8% |
| South | 697 | 34,944 | 9,025,016 | 35.5% | 18 | 1,819 | 467,420 | 30.0% |
| West | 251 | 15,831 | 4,206,629 | 16.5% | 14 | 1,615 | 385,345 | 24.8% |
| Other/Unknown | 8 | 603 | 170,477 | 0.7% | 0 | 0 | 0 | 0.0% |

⁴⁷ A small number of facilities included in this analysis did not provide applicable psychiatric beds and/or psychiatric days information on Worksheet S-3 of their 2016 HCRIS cost reports. This missing information means that total costs may be underestimated, since national cost estimates were calculated on a per-day basis based on the number of days reported by psychiatric facilities in their 2016 HCRIS cost reports.

psychiatric hospital vs. general acute care hospital). Total estimated national annual compliance costs for each facility type were then summed to generate a national total cost for each regulatory issue for all 1,738 inpatient psychiatric facilities nationwide. Finally, the total estimated annual costs for each issue by facility type were then used to calculate cost-per-licensed-bed metrics, based on the number of licensed psychiatric inpatient beds observed in HCRIS.

For the five-year physical plant and equipment cost-per-psychiatric-bed metrics reported in the Ligature Risk section (discussed above), the applicable costs generated from the survey (cost per staffed bed) were weighted to the national total count of licensed psychiatric beds by provider type. To account for the gap between staffed and licensed beds, data from the 2016 American Hospital Association annual survey was linked to the 2016 HCRIS data to identify the ratio of staffed to licensed beds for inpatient psychiatric hospitals. Based on the data for inpatient psychiatric facilities that could be appropriately linked between the two datasets on their Medicare provider identifier (57 percent of total inpatient psychiatric facilities), the ratio of staffed to licensed psychiatric beds is roughly 93.6 percent. This ratio was applied as a discount factor to reduce the estimated per licensed bed cost.

Psychiatric Inpatient All-Payer Net Patient Revenues

Psychiatric hospital inpatient all-payer net patient revenues were estimated based on data provided by SAHMSA, in a 2019 publication titled “Behavioral Health Spending & Use Accounts 2006–2015.” In this report, SAHMSA integrates data from the CMS National Health Expenditure Accounts (NHEA) dataset with multiple other data sources to estimate total national spending on behavioral health services, segmented by service type and provider type. SAHMSA reports a total mental health inpatient care cost of \$31.3 billion. Using an alternate method integrating multiple data points from this report, the authors estimate a slightly lower number (\$30.0 billion) in total spending on psychiatric inpatient hospital services provided in freestanding psychiatric hospitals and general acute hospital specially licensed psychiatric units in 2015. The higher number is used in this report, to generate a more conservative estimate of regulatory burden costs as a share of total all-payer inpatient psychiatric hospital patient service revenue.

The authors utilized trend data provided in the same SAHMSA report to generate current (2019) spending

estimates. The average annual 2006–2015 trend in inpatient psychiatric service spending per year was 3.1 percent. Projecting this trend forward from 2015 to 2019, the authors estimate a total nationwide all-payer inpatient psychiatric service spending of \$35.4 billion in 2019. This denominator (\$35.4 billion) was used to calculate the national regulatory burden cost as a share of all-payer inpatient psychiatric service revenue.

APPENDIX B: CHARTS AND TABLES

Table B-1: Regulatory Burden, Estimated Annual National Cost

| Regulatory Burden Issue | Estimated Total Regulatory Burden Annual Cost (Millions) |
|---|--|
| | All Inpatient Psychiatric Facilities |
| OVERALL Composite - All Three Regulatory Burden Domains | \$1,715.9 |
| EMTALA Composite | \$209.6 |
| E1 - Emergency Medical Screenings | \$201.6 |
| E2 - Involuntary Admissions | \$8.0 |
| LIGATURE RISK Composite | \$880.4 |
| L1 - Physical Environment | \$637.5 |
| L2 - 1:1 Monitoring | \$242.9 |
| B-TAG Composite | \$625.9 |
| B1 - Treatment Plan | \$201.1 |
| B2a - Minimum Qualifications (Director of Inpatient Psychiatric Services) | \$71.4 |
| B2b - Minimum Qualifications (Director of Psychiatric Nursing Services) | \$66.9 |
| B2c - Minimum Qualifications (Director of Social Services) | \$39.3 |
| B3 - Psychiatric Evaluations | \$194.0 |
| B4 - Neurological Screenings | \$53.1 |

Table B-2: Regulatory Burden, Estimated Cost Per 100 Psychiatric Inpatient Days

| Regulatory Burden Issue | Estimated Annual Regulatory Burden Cost Per 100 Psych Inpatient Days |
|---|--|
| | All Inpatient Psychiatric Facilities |
| OVERALL Composite - All Three Regulatory Burden Domains | \$6,747.19 |
| EMTALA Composite | \$824.09 |
| E1 - Emergency Medical Screenings | \$792.60 |
| E2 - Involuntary Admissions | \$31.49 |
| LIGATURE RISK Composite | \$3,462.07 |
| L1 - Physical Environment | \$2,506.94 |
| L2 - 1:1 Monitoring | \$955.14 |
| B-TAG Composite | \$2,461.03 |
| B1 - Treatment Plan | \$790.78 |
| B2a - Minimum Qualifications (Director of Inpatient Psychiatric Services) | \$280.69 |
| B2b - Minimum Qualifications (Director of Psychiatric Nursing Services) | \$263.03 |
| B2c - Minimum Qualifications (Director of Social Services) | \$154.61 |
| B3 - Psychiatric Evaluations | \$762.95 |
| B4 - Neurological Screenings | \$208.96 |

Table B-3: Regulatory Burden, Estimated National Annual Cost Per Licensed Psychiatric Bed

| Regulatory Burden Issue | Estimated Annual Regulatory Burden Cost Per Licensed Psychiatric Bed |
|---|--|
| | All Inpatient Psychiatric Facilities |
| OVERALL Composite - All Three Regulatory Burden Domains | \$18,362.76 |
| EMTALA Composite | \$2,242.79 |
| E1 - Emergency Medical Screenings | \$2,157.09 |
| E2 - Involuntary Admissions | \$85.70 |
| LIGATURE RISK Composite | \$9,422.17 |
| L1 - Physical Environment | \$6,822.73 |
| L2 - 1:1 Monitoring | \$2,599.44 |
| B-TAG Composite | \$6,697.79 |
| B1 - Treatment Plan | \$2,152.15 |
| B2a - Minimum Qualifications (Director of Inpatient Psychiatric Services) | \$763.90 |
| B2b - Minimum Qualifications (Director of Psychiatric Nursing Services) | \$715.86 |
| B2c - Minimum Qualifications (Director of Social Services) | \$420.78 |
| B3 - Psychiatric Evaluations | \$2,076.41 |
| B4 - Neurological Screenings | \$568.69 |

Table B-4: Regulatory Burden, Estimated National Annual Cost as % of Estimated All-Payer Inpatient Psychiatric Service Revenue

| Regulatory Burden Issue | Estimated Annual Regulatory Burden Cost as % of All-Payer Inpatient Psychiatric Service Revenue |
|---|---|
| | All Inpatient Psychiatric Facilities |
| OVERALL Composite - All Three Regulatory Burden Domains | 4.84% |
| EMTALA Composite | 0.59% |
| E1 - Emergency Medical Screenings | 0.57% |
| E2 - Involuntary Admissions | 0.02% |
| LIGATURE RISK Composite | 2.48% |
| L1 - Physical Environment | 1.80% |
| L2 - 1:1 Monitoring | 0.68% |
| B-TAG Composite | 1.76% |
| B1 - Treatment Plan | 0.57% |
| B2a - Minimum Qualifications (Director of Inpatient Psychiatric Services) | 0.20% |
| B2b - Minimum Qualifications (Director of Psychiatric Nursing Services) | 0.19% |
| B2c - Minimum Qualifications (Director of Social Services) | 0.11% |
| B3 - Psychiatric Evaluations | 0.55% |
| B4 - Neurological Screenings | 0.15% |

APPENDIX C: MEDICARE CONDITIONS OF PARTICIPATION FOR PSYCHIATRIC HOSPITALS (CMS REGULATIONS)

Special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60)

Psychiatric hospital must—

- (a) Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons;
- (b) Meet the conditions of participation specified in §§ 482.1 through 482.23 and §§ 482.25 through 482.57;
- (c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries, as specified in § 482.61; and
- (d) Meet the staffing requirements specified in § 482.62.

Condition of participation: Special medical record requirements for psychiatric hospitals (42 C.F.R. § 482.61)

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

- (a) Standard: Development of assessment/diagnostic data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.
 - (1) The identification data must include the patient's legal status.
 - (2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.
 - (3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.
 - (4) The social service records, including reports of interviews with patients, family members, and others,

must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

- (5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(b) Standard: Psychiatric evaluation. Each patient must receive a psychiatric evaluation that must—

- (1) Be completed within 60 hours of admission;
- (2) Include a medical history;
- (3) Contain a record of mental status;
- (4) Note the onset of illness and the circumstances leading to admission;
- (5) Describe attitudes and behavior;
- (6) Estimate intellectual functioning, memory functioning, and orientation; and
- (7) Include an inventory of the patient's assets in descriptive, not interpretative, fashion.

(c) Standard: Treatment plan.

- (1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient's strengths and disabilities. The written plan must include—
 - (i) A substantiated diagnosis;
 - (ii) Short-term and long-range goals;
 - (iii) The specific treatment modalities utilized;
 - (iv) The responsibilities of each member of the treatment team; and
 - (v) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.

(d) Standard: Recording progress. Progress notes must be recorded by the doctor of medicine or

osteopathy responsible for the care of the patient as specified in § 482.12(c), nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

(e) Standard: Discharge planning and discharge summary. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

Condition of participation: Special staff requirements for psychiatric hospitals (42 C.F.R. § 482.62)

The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning.

(a) Standard: Personnel. The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:

- (1) Evaluate patients;
- (2) Formulate written individualized, comprehensive treatment plans;
- (3) Provide active treatment measures; and
- (4) Engage in discharge planning.

(b) Standard: Director of inpatient psychiatric services; medical staff. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

(1) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

(c) Standard: Availability of medical personnel. Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.

(d) Standard: Nursing services. The hospital must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient.

(1) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

(2) The staffing pattern must ensure the availability of a registered professional nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.

(e) Standard: Psychological services. The hospital must provide or have available psychological services to meet the needs of the patients.

(f) Standard: Social services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures.

(1) The director of the social work department or service must have a master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a masters degree in social work, at least one staff member must have this qualification.

(2) Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate, information with sources outside the hospital.

(g) Standard: Therapeutic activities. The hospital must provide a therapeutic activities program.

(1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

(2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.

Note: Largely identical regulations applicable to inpatient psychiatric units in general hospitals appear at 42 C.F.R. § 412.27.

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