NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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March 31, 2014

Ms. Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS–3178–P: "Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers"

Dear Ms. Tavenner,

As an association representing hospitals and other behavioral healthcare provider organizations as well as professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule (CMS–3178–P) titled "Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers" as published in the December 27, 2013, *Federal Register*.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 700 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including inpatient care, residential treatment, partial hospitalization, and outpatient services.

COMMENTS

NAPHS is aware that various hospital associations and others are preparing detailed comments related to the overall requirements for hospitals as outlined in the proposed rule. We will not attempt to duplicate those comments. We will focus on psychiatric residential treatment facilities (PRTFs) and freestanding psychiatric hospitals.

COMMENTS RELATED TO REQUIREMENTS FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFs)

In the preamble, the proposed rule states (p. 79107) that, "we propose requiring that PRTF facilities meet the same requirements we are proposing for hospitals." Unlike hospitals, PRTFs are not first receivers. It is not their mission to provide medical care to injured or acutely ill victims of a disaster nor to triage patients. It is their mission to provide continuing care and treatment to existing inpatients and to provide for their safe transfer when, based on the nature of the disaster, that is necessary. This is a distinction that makes the application of "the same requirements we are proposing for hospitals" inappropriate.

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Within PRTFs, there is significant variation in size and complexity of organizations that affects a provider's role within the emergency response plan and the reasonable expectation for development of plans that may never be used.

The proposed rule itself, as it is applied to PRTFs (441.184), does not appear to include all hospital requirements. Could you please clarify if you intend to make any distinctions? We are concerned that being required to meet the same requirements as proposed for hospitals may overwhelm the capacity of many PRTFs. PRTFs are an essential component in the continuum of care for children and adolescents who are Medicaid beneficiaries.

We agree with the proposed rule that current PRTF requirements do not **directly** include any requirements for emergency preparedness. However, PRTFs are required to be accredited by one of the major accrediting organizations (The Joint Commission, the Council on Accreditation, CARF). There are Emergency Management standards within, for example, The Joint Commission behavioral healthcare requirements that are deemed to be appropriate to PRTFs. These standards include requirements for care, treatment, or services for individuals served; communications; resources and assets; safety and security; and staff responsibilities. They address mitigation, preparedness, response, and recovery. However, the depth and breadth of the standards compliance is not the same as those for hospitals because PRTFs do not have the complexity of services, vulnerabilities, and community responsibility that a hospital has.

We note the use of phrases such as, "we believe PRTFs need maximum flexibility in determining the way to best accomplish this task (p. 79128)." While we are not advocating for increased prescriptiveness, we are concerned about how such phrases will translate into Interpretive Guidelines and surveyor decisions. These decisions make providers very vulnerable to deficiencies and directly affect their ability to stay in business.

The proposed rule states that PRTFs must comply with all applicable Federal and State emergency preparedness requirements. We are aware that these requirements are often not consistent and would appreciate clarification about giving deference to the appropriate authorities having jurisdiction.

While we agree that planning with community officials in advance of an emergency is a very important activity, we are concerned by the term "ensure" in the context of the phrase, "Include a process ensuring cooperation and collaboration with local, tribal regional, State and Federal emergency preparedness officials…" We also note the requirement to "participate in a community mock disaster drill at least annually." We know from our members that they are at times not included, despite their willingness and requests, in the larger community preparedness plan. While we think it is very important that PRTFs be included in community planning and disaster drills, no individual facility can "ensure" its participation. We would appreciate clarification that documentation of best efforts to be a part of the community plan would meet this requirement. We also recommend that, if a mock drill has been conducted, there should be no requirement for a "table-top" exercise annually.

We support the decision not to require specific subsistence stockpile amounts for inpatient providers. We do not agree that inpatient providers should consider the needs of visitors and individuals from the community. In a disaster, the needs of persons who are not patients and staff should be provided for as they would for any member of the community as part of the community preparedness plan (Red Cross, etc.).

The regulations appear to use the term "volunteers" without definition. We ask that the term be limited to State and Federally designated healthcare professionals being used to address surge needs during an emergency.

We would appreciate clarification of the CMS intent relative to the "role of the PRTF under a waiver declared by the Secretary, in accordance with section 1135 of the Act in the provision of care and treatment at an alternate care site identified by emergency management officials." We are aware of the provisions of section 1135, but wonder how this would be operationalized relative a PRTF.

The burden calculation of $1,071,990 for compliance with the regulations by the 387 PRTFs seems extremely low. The time allotted for each function appears to significantly underestimate the time and resources that would actually be required (including content expertise that does not necessarily exist within a small organization and that would need to be contracted for). This leads us to seriously question whether CMS is really aware of the scope and resource intensity of the requirements they are proposing.

COMMENTS RELATED TO REQUIREMENTS FOR FREESTANDING PSYCHIATRIC HOSPITALS

We do not intend to comment on all elements of the proposed rule related to hospitals, but wish to point out selected areas where the capacity and capability of freestanding psychiatric hospitals need special note.

Freestanding psychiatric hospitals are required to meet all existing CMS Hospital Conditions of Participation. However, we point out that in the area of emergency management psychiatric hospitals do not function as first receivers or triage facilities. It is not their mission to provide medical care to injured or acutely ill victims in a disaster. They provide the full scope of psychiatric services and can be a significant resource to the community in a disaster. However, they do not provide the full scope of emergency services a general hospital can provide.

The proposed rule states that hospitals must comply with all applicable Federal and State emergency preparedness requirements. We are aware that these requirements are often not consistent and would appreciate clarification about giving deference to the appropriate authorities having jurisdiction.

While we agree that planning with community officials in advance of an emergency is a very important activity, we are concerned by the term “ensure” in the context of the phrase, “Include a process ensuring cooperation and collaboration with local, tribal regional, State and Federal emergency preparedness officials…” We also note the requirement to, “participate in a community mock disaster drill at least annually.” We know from our members that they are at times not included in the larger community preparedness plan, despite their willingness and request to be included. The larger community may not understand what psychiatric hospitals can contribute or what they might need in the face of disaster. While we think it is very important that psychiatric hospitals be included in community planning and disaster drills, no individual facility can “ensure” its participation. We would appreciate clarification that documentation of best efforts to be a part of the community plan would meet this requirement. We also recommend that, if a mock drill has been conducted, there should be no requirement for a “table-top” exercise annually.

We support the decision not to require specific subsistence stockpile amounts for inpatient providers. We do not agree that inpatient providers should consider the needs of visitors and individuals from the community. In a disaster, the needs of persons who are not patients and staff should be provided for as they would for any member of the community as part of the community preparedness plan (Red Cross, etc.).

The regulations appear to use the term “volunteers” without definition. We ask that the term be limited to State and Federally designated healthcare professionals being used to address surge needs during an emergency.

The burden of compliance for psychiatric hospitals (as a subset of all hospitals) could be disproportionately high. As generally smaller organizations than typical general hospitals, psychiatric hospitals may need to contract for content expertise that does not necessarily exist within a smaller organization.

RECOMMENDATION

NAPHS recommends that CMS use the considerable comments to the proposed rule it will receive from the field to further refine and align the proposed emergency preparedness requirements with other requirements such as accrediting organizations, federal emergency preparedness agencies, and state authorities. It should then be possible to identify the areas that are not adequately covered by these entities and to focus on the areas where CMS needs to fill gaps consistent with its mission. It is our hope

that this would result in a more focused, less duplicative and competing set of CMS requirements. Providers would, hopefully, be able to target scarce resources toward critical issues that are under their control. It could also lead to a better understanding of providers' roles as partners with the Department of Homeland Security through the National Incident Management System as it has been tasked with the development and operationalization of the emergency preparedness system (Presidential Policy Directive 8).

Thank you for your consideration of our comments. We look forward to working with CMS and the Department of Health and Human Services to ensure appropriate emergency preparedness requirements for organizations serving Medicare and Medicaid beneficiaries.

Sincerely,

/s/

Mark Covall
President/CEO