National Association of Psychiatric Health Systems

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

RE: CMS–3244–P: Proposed Rule: "Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation" (42 CFR Parts 482 and 485)

Dear Ms. Tavenner,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to respond to the proposed rule (CMS-3244-P) titled "Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation" as published in the October 24, 2011, *Federal Register*. We are happy to provide our suggestions – particularly related to behavioral health organizations that provide services to those who are experiencing mental and addictive disorders.

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 treatment, residential treatment, partial hospitalization, and outpatient services.

As behavioral healthcare providers, we care for millions of individuals with serious and persistent mental illnesses and serious addictive disorders, many of whom are enrolled in the Medicare and Medicaid programs.

COMMENTS

We support the underlying concept of reducing regulatory burden on healthcare providers. In an era of limited resources, every possible dollar should be targeted to direct patient care – not to excessive administrative burden. We thank CMS for its careful review of the issue.

We support the CMS recommendations to:

- Grant privileges to both physicians and non-physicians to practice within the scope of practice allowed by state law;
- Allow drugs and biological to be prepared and administered, as well as documented and signed, on the orders of practitioners other than those specified under §482.12(c);
- Allow a practitioner to authenticate orders as long as that practitioner is one who is responsible for the patient's care and has the authority to write orders (rather than allowing only the ordering practitioner to authenticate the orders).
- Eliminate the authentication of verbal orders within 48 hours, if no state law exists mandating another timeframe;
- Eliminate the infection control log as long as the information is retrievable in other ways;
- Allow the nursing care plan to be integrated into an interdisciplinary treatment plan. This is particularly important for providers of psychiatric services since we are required to develop an interdisciplinary plan that includes all relevant disciplines.

In addition to the recommendations made in the proposed rule, we suggest that CMS review the Medicare Condition of Participation: Special Provisions Applying to Psychiatric Hospitals (§482.60). These special conditions include staffing and medical records requirements that apply only to psychiatric hospitals and are intended to demonstrate that psychiatric patients are receiving the active treatment required of all hospitals for reimbursement under Medicare. The conditions have not been substantively changed since their inception in 1965 and, in certain places, do not support the extraordinary changes that have taken place in the provision of psychiatric hospital services since the 1960s. Goals for hospitalization and treatment interventions have changed significantly in the last 40 years.

As one point of reference, the length of hospitalization for a typical patient in the mid-1960s was at least 30 days, with many Medicare-eligible beneficiaries being hospitalized for 90 days or more. Today the average length of stay for Medicare beneficiaries is approximately 10 days. In the 1960s and 1970s patients were hospitalized for the definitive resolution of the acute exacerbation of their psychiatric illness. Today hospitalization is geared almost exclusively to crisis intervention and discharge planning. The acuity of psychiatric patients in hospitals is very high, and there is no question that they require and receive active treatment.

Staff consistently report that significant time and resources are spent meeting the documentation requirements of the special conditions when a much more focused approach would more appropriately meet the patients' acute care needs and free staff for direct care. The conditions are also very prescriptive regarding the members of the treatment team and evidence that they are participating in formal interdisciplinary treatment team meetings held for the purpose of treatment planning and evaluation. There is a need for flexibility in developing models that are more individualized and efficient without providers running the risk of being found out of compliance with the conditions—leading, at worst, to decertification and too often to lengthy processes of writing plans of correction and experiencing multiple resurveys to determine compliance.

For these reasons, we suggest that the composition of the required treatment team, the specificity of assessments, and the requirements of the interdisciplinary treatment plan should be revised to support a crisis intervention model rather than the longer-term model being delivered at the time of their inception.

While we support a total review of the psychiatric hospital conditions over time, for the immediate purpose of reducing burden, we suggest review of the following specific standards within the conditions. This list is not intended to be all-inclusive but to give examples of the kinds of requirements that need to be changed. We are able to provide much more detail about the specific elements that add significant regulatory burden without concomitant clinical benefit.

§482.61(b) The requirements for the psychiatric, social work, and neurological exams are too specific. More flexibility for professional judgment regarding the breadth and depth of assessments should be allowed through the development of hospital-specific policies rather than requirements of conditions of participation.

482.61(c) The requirements for the individual comprehensive treatment plan are very prescriptive and, for many patients, are not appropriate for the short-term, crisis-oriented focus of their current hospitalization. We suggest there are other ways to assure that patients are receiving appropriate treatment modalities with sufficient frequency and intensity to justify inpatient treatment than are currently required by the conditions of participation.

482.62 (a) We fully support the requirement that hospitals must "provide adequate numbers of qualified professional, technical, and consultative personnel" to evaluate and care for patients. However, we suggest that the provision of interdisciplinary treatment can be accomplished in many ways and that hospitals should be encouraged to provide that treatment in the most flexible and efficient way possible, based on individual patient needs and hospital policy.

CONCLUSION

We look forward to continuing to work with CMS and the Department of Health and Human Services to reduce unnecessary regulatory burden so that resources can more effectively be directed to support quality services for Medicare and Medicaid beneficiaries.

Sincerely,

/s/

Mark Covall
President/CEO