MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION

OMB SUBMISSION: REQUEST FOR APPROVAL OF OMB CLEARANCE

SUPPORTING STATEMENT- PART A

A. BACKGROUND

Under the provisions of section 2707 of the Patient Protection and Affordable Care Act of 2010 (See Attachment A), the Centers for Medicare & Medicaid Services (CMS) is conducting the Medicaid Emergency Psychiatric Demonstration. This is a 3-year Demonstration that permits participating States to provide payment under the State plan to private psychiatric hospitals for inpatient emergency psychiatric care to Medicaid recipients aged 21 to 64 who have expressed suicidal or homicidal thoughts or gestures and are determined to be dangerous to themselves or others.

The goal of the Demonstration is to assess whether this expansion of Medicaid coverage to include services provided in private, free-standing inpatient psychiatric facilities improves access to and quality of medically necessary care and whether this change in reimbursement policy is cost-effective. Focusing on psychiatric emergencies, the Demonstration is also an attempt to explore a potential remedy to alleviate one of the factors contributing to psychiatric boarding, one of the consequences associated with the Medicaid institutions for mental diseases (IMD) exclusion.

State Medicaid Agencies will be invited to submit application proposals to participate in the Demonstration. The following is a description of the Demonstration beginning with a historical framework to understand the intent of the Demonstration and the problems it is intended to address followed by a description of the Demonstration design and requirements for State participation and the instructions for preparing an application protocol.

B. JUSTIFICATION

B.1 Circumstances Making the Collection of Information Necessary

B.1.1 Deinstitutionalization and the Medicaid IMD Exclusion

The creation in the United States of regional State mental hospitals in the 19th Century was largely a responsive and humane alternative to the frequent practice of confining the indigent mentally ill under squalid conditions in almshouses and prisons (Torrey, 1997). Continuing into the mid-20th Century, the treatment of serious mental illness was now usually provided through inpatient admissions in a private or State funded mental hospital. However, at the same time, mental hospitals, particularly public institutions, had increasingly become known for their overcrowded and poor hygienic conditions. Although many inpatient treatment modalities were available at these institutions, their effectiveness was often equivocal, condemning those with more serious mental illnesses to years of largely custodial inpatient care. With the advent of a new class of psychotropic drugs in the mid-1950s, specifically the anti-psychotic medication chlorpromazine, it was found that many persons with mental illnesses could be effectively

treated in an outpatient setting. This began a movement away from institutionalization, toward community-based treatment and the establishment of community mental health centers. This transition became known as "deinstitutionalization" which was in keeping with the principle that severe mental illness should be treated in the least restrictive setting (Torrey, 1997).

It has been a long-standing policy of the Federal government that the States should bear the responsibility for funding inpatient psychiatric facilities and so for many years the States and counties provided all funding for inpatient care within a network of State and local municipal mental institutions. This policy guided future legislation including the amendments to the Social Security Act in 1950 whereby patients in mental institutions were excluded from receiving Federal payments for old-age assistance (Geller, 2000). Another factor supporting such an exclusion in this and subsequent legislation may have been that many in Congress apparently believed that State mental institutions were simply warehouses which furnished no effective treatment and thus were inappropriate for coverage (Rosenbaum, Teitelbaum, and Mauery, 2002).

The legislation establishing Medicaid continued this coverage exclusion but deviated somewhat from the policy by allowing Federal matching funds for inpatient mental health care in psychiatric institutions for individuals aged 65 and older.

The Social Security Administration of 1972 legislation expanded Medicaid coverage to include inpatient care for individuals under age 21 in "institutions for mental diseases" or IMDs. An IMD is defined as a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services (42 U.S.C. 1396d). It is important to note that the payment exclusion does not apply to inpatient treatment for mental diseases in facilities that are part of larger medical entities, such as general hospitals or skilled nursing facilities, as long as the majority of the patient population was admitted and treated for reasons other than mental disease.

As part of the Medicare Catastrophic Act of 1988 (P.L. 100-360), Congress further defined an IMD as a facility with more than 16 beds. This was apparently added to promote small community-based group living arrangements as an alternative to large institutions. Thus, after these amendments, today Medicaid provides mental health treatment coverage for a large percentage of Medicaid entitlee's, but coverage is excluded for inpatient treatment of adults aged 21-64 in any stand-alone, acute or long-term care institutions with 17 or more beds that provide treatment for mental diseases. This payment exclusion became known as the Medicaid IMD exclusion.

With deinstitutionalization came a commensurate reduction over time in the number of psychiatric beds through downsizing and closures, particularly of the regional State mental hospitals. Although unrelated to the deinstitutionalization movement, the Medicaid IMD exclusion provided an incentive to shift the cost of care for mental diseases to other care modalities and facilities where Medicaid matching funding was available and indirectly contributed to the decrease in the number of publicly funded inpatient psychiatric beds. As a

consequence, the Medicaid IMD exclusion may be a contributing factor to psychiatric boarding and recidivism in general hospital emergency departments.

B.1.2 Emergency Medical Treatment and Active Labor Act (EMTALA)

In 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd), was enacted in response to concerns that some emergency departments across the country had refused to treat indigent and uninsured patients or inappropriately transferred them to other hospitals, a practice known as "patient dumping." EMTALA requires hospitals that participate in Medicare to provide a medical screening examination to any person who comes to the emergency department, regardless of the individual's ability to pay.

If a hospital determines that the person has an emergency medical condition (EMC), it must provide treatment to stabilize the condition or provide for an appropriate transfer to another facility (U.S. GAO, 2001). For psychiatric emergencies, an EMC is defined as an individual expressing suicidal or homicidal thoughts or gestures, and determined dangerous to self or others (CMS, 2010).

A hospital's EMTALA obligation ends when a physician, or qualified medical person, decides: that no EMC exists (even though the underlying medical condition may persist); that an EMC exists and the individual is appropriately transferred to another facility; or that an EMC exists and the individual is admitted to the hospital for further stabilizing treatment (CMS, 2010).

In the case of individuals eligible for Medicaid who require immediate treatment for a psychiatric emergency, EMTALA requires a Medicare participating hospital to provide treatment until the individual's condition is stabilized and/or transferred to an inpatient facility where the person can be treated until the condition is stabilized.

Psychiatric patients are considered stabilized when they are protected and prevented from injuring or harming themselves or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC. However, the underlying medical condition may persist and if not treated appropriately, the EMC may resurface.

A Medicare-participating hospital with specialized capabilities may not refuse to accept an appropriate transfer from another hospital of an individual protected under EMTALA who has an unstabilized EMC requiring these specialized capabilities. This requirement to accept an appropriate transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department. In this case, if an individual is found to have an EMC that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare, and has capacity, is obligated to accept an appropriate transfer of that individual. It does not matter if the psychiatric hospital does not have a dedicated emergency department (CMS, 2010).

Medicaid will cover inpatient psychiatric admissions in an IMD for children under age 21 and adults over age 64. However, for Medicaid recipients aged 21 to 64, Medicaid will only cover the cost of such admissions as long as the inpatient psychiatric care is provided in a mental health facility which has less than 17 beds or a medical facility whose primary purpose is not the provision of treatment for mental disease.

Since psychiatric hospitals with 17 or more beds are required to admit these Medicaid patients for stabilization of an emergency medical condition requiring psychiatric capabilities, and these individuals are not commonly insured by other health plans, the EMTALA statute often amounts to a mandate for psychiatric hospitals to render uncompensated care to these individuals.

B.1.3 Psychiatric Boarding

The Medicaid IMD exclusion, is purported to be a major factor contributing to the rate of "psychiatric boarding" in hospital emergency departments (DHHS, 2008). Psychiatric boarding occurs when an individual with a mental disorder is kept in a hospital emergency department for several hours because appropriate mental health services are unavailable. Emergency departments are required to provide treatment to stabilize or transfer these patients in accordance with EMTALA. Thus, even if a psychiatric bed is available at an outside facility, the boarding time may be extended when there is uncertainty as to whether a patient's condition meets the EMTALA definition of "stabilized" for transfer. The result is a disruption in the continuity of care directed at the patient and the overall diminished quality of care provided to the patient at the most critical period of the treatment episode.

In the case of more serious mental disorders requiring inpatient admission, boarding can include improper placement, for instance, to a bed on a medical ward or in a skilled nursing facility, when a psychiatric bed at the hospital or at a referral facility outside the hospital would be more appropriate but is not available (DHHS, 2008). This situation becomes even more acute when the individuals seen are suicidal or homicidal and present a danger to themselves or others. It appears that these cases are most often referred to non-government psychiatric facilities specializing in emergency conditions and short-term hospitalizations as more and more, the State mental hospitals have limited their bed space to long-term resident admissions focusing on the treatment of chronic psychiatric illnesses.

Although a comprehensive, nationwide evaluation of psychiatric boarding has not been completed, there appears to be ample survey and anecdotal information to indicate that it is a frequent and prevalent problem leading to serious consequences for psychiatric patients and unnecessary hospital costs (DHHS, 2008).

B.1.4 Demonstration Legislation

Section 2707 of the Patient Protection and Affordable Care Act was enacted to implement a demonstration to study the effects of allowing Medicaid payment for the inpatient stabilization of a more serious mental health related problem. That is, to provide payment for inpatient stabilization for psychiatric patients aged 21 to 64 who express suicidal or homicidal gestures and are considered a danger to themselves or others.

By allowing coverage for inpatient admission for emergency psychiatric treatment otherwise prohibited by the Medicaid IMD exclusion, the Demonstration may improve access to appropriate psychiatric care, improve quality of care for Medicaid patients, and encourage greater availability of inpatient psychiatric beds, thereby reducing the necessity of psychiatric boarding.

Section 2707 of the Patient Protection and Affordable Care Act authorizes a 3-year Medicaid emergency psychiatric demonstration project that permits non-government psychiatric hospitals to receive Medicaid payment for providing EMTALA-related emergency services to Medicaid recipients aged 21 to 64 who have expressed suicidal or homicidal thoughts or gestures and are determined to be dangerous to themselves or others. Under the Demonstration, participating States shall provide payment under the State Medicaid Plan to an institution for mental diseases that is not publically owned or operated and is subject to the requirements of EMTALA.

B.1.5 Statutory Waiver Authority

Under section 2707 of the Patient Protection and Affordable Care Act, authority is provided to waive requirements of titles XI and XIX of the Social Security Act, including the requirements of sections 1902(a)(1) relating to state-wideness, and 1902(1)(10)(B) relating to comparability, to the extent necessary to carry out this demonstration. The statute provides specific waiver authority to allow State Medicaid payment and Federal matching funds for current IMD exclusion qualifying services for States that participate in this Demonstration.

B.1.6 Demonstration Design

There are several requirements stated or implied by the statute that guide the implementation and operation of the Demonstration. The following is an outline of the design of the Medicaid Emergency Psychiatric Demonstration following the parameters set by the section 2707 statue.

B.1.7 State Solicitation and Selection

States seeking to participate in the Demonstration project will submit an application to CMS. The application instructions, mailing address and due date are provided in a separate attachment (see Appendix 1). States submitting applications to participate in the Demonstration will be selected on a competitive basis based on their responses to the application subject areas. The selection will also include factors necessary to achieve an appropriate national balance in the geographic distribution of the Demonstration.

B.1.8 Selection Process

Application proposals will be provided to an application review panel composed of subject matter experts that will determine the responsiveness of each proposal to the solicitation and score each proposal based on pre-determined criteria. The rank order listing of panel recommendations will be provided to the CMS Administrator for final selection. Two additional factors will guide the final selection. First, in accordance with the statute, the selection of States will be guided by an effort to achieve a balance in the geographic distribution of the

Demonstration. Second, the number of States selected for the Demonstration must necessarily be limited by the amount of funding and so, based on anticipated patient census, the total number of States selected will be limited so as to allow all selected States the opportunity to precipitate in the demonstration for the full 3-year period.

B.1.9 Participating Institutions

Institutions selected by a participating State for inclusion in the Demonstration must meet all of the following criteria:

(1) An institution for mental diseases, defined specifically as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services {SSA section 1905(i), 42 USC 1395(i))} and, in general, meeting the requirements of Section 4390 of the State Medicaid Manual (see Appendix 2).

(2) An institution subject to the requirements of the Emergency Medical Treatment and Active Labor Act or EMTALA {SSA section 1867, 42 U.S.C. 1395d}, i.e., a Medicare participating institution having an emergency department.

(3) Not be publicly owned or operated.

Note: Some discussion should be made here about the requirement in the statute that payment can be made only to institutions for mental disease that are subject to EMTALA. Paraphrasing section 2707 of the Patient Protection and Affordable Care Act, it stipulates that payment will be made under the Demonstration to institutions for medical diseases that are not publically owned or operated and are subject to the requirements of the Emergency Medical Treatment and Active Labor Act for the provision of medical assistance to Medicaid eligible individuals aged 21 to 64 requiring stabilization of an emergency medical condition. As mentioned in the section above on EMTALA, the Medicare State Operational Manual interpretive guidelines state that EMTALA applies to a psychiatric facility in those instances in which it accepts transfer of a patient needing stabilization of an emergency medical condition that requires the specialized psychiatric capabilities of the psychiatric facility, even though the facility has no emergency department. Thus, all Medicare- participating hospitals that are institutions for mental disease are subject to EMTALA in the way and manner stipulated in section 2707 and thus also meet the requirement to receive payment under the Medicaid Emergency Psychiatric Demonstration.

This interpretation is expanded to walk-in emergency admissions by a response entered into the final rule for the application of EMTALA published in 1994 (DHHS/HCFA/OIG, 1994) which states:

"…many psychiatric hospitals do not have organized emergency departments. However, many of these facilities offer 24-hour psychiatric services on a walk-in basis for persons who are not patients of the hospital. Although these hospitals do not have organized emergency departments, they are presenting themselves to the public as providing care for psychiatric emergencies. We believe this type of facility must comply with the requirements of section 1867 of the Act and

render emergency care within their capability to do so (or provide for a transfer in accordance with section 1867(c) of the Act)."

B.1.10 Patient Eligibility Criteria

Individuals eligible for the provision of medical assistance available under the Demonstration are those meeting all of the following criteria:

(1) Aged 21 to 64;

(2) Eligible for medical assistance under the State plan; and

(3) Require such medical assistance for services to stabilize an emergency medical condition where the individual expresses suicidal or homicidal thoughts or gestures and is determined dangerous to self or others.

The Demonstration is open only to individuals meeting these criteria who receive medical assistance under the State's Medicaid fee-for-service program and includes individuals eligible by virtue of the authority of section 1115 of the Social Security Act. Also eligible, for inclusion in this Demonstration, are individuals in managed care plans whose eligibility and payment for inpatient psychiatric services is Medicaid fee-for-service (i.e., carved out).

The State may extend participation in the Demonstration to eligible individuals throughout the State or limit participation to individuals residing in one or more specific regions.

B.1.11 Demonstration Management

CMS is responsible for overseeing the implementation, management and evaluation of the Demonstration. Each selected State, and participating institutions within the State, is a Demonstration site. The State is responsible for overseeing the implementation and operation of the Demonstration at the participating institutions, verifying patient eligibility and assuring that appropriate services are provided within the parameters set by the section 2707 statute.

B.1.12 Patient Administration

As stated in the statute, each participating State shall establish a process for how it will ensure that institutions participating in the Demonstration will determine whether or not Demonstration patients have been stabilized, the process to be initiated by the State prior to the third day of an inpatient stay. The State is responsible for managing the provision of services for the stabilization of the medical emergency through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavior health.

B.1.13 Payment to Participating Institutions

The State Medicaid Agency will provide Medicaid payment to participating institutions for services provided to eligible patients under the Demonstration.

B.1.14 CMS Payment to States

The CMS will pay each quarter, to each participating State, an amount equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance paid to participating institutions for inpatient services provided under this Demonstration.

Funds shall be allocated to eligible States on the basis of criteria, including availability of funds and predicted patient admissions and costs. State Medicaid Agencies are advised that once the Federal funding limit is reached, states will not receive payment of the Federal share of any outstanding Medicaid expenditures.

B.1.15 Cost Estimate and Mechanism to Limit, Reallocate and Stop Expenditures

Section 2707 of the Patient Protection and Affordable Care Act requires that payment to States to reimburse the Federal share of Medicaid costs under the Demonstration shall not exceed $75 million. Although the statute authorizing the Demonstration has appropriated $75 million to pay the Federal share of Medicaid payments provided under the Demonstration, the statute allows for the use of these funds to pay Federal administrative and evaluation costs for the Demonstration. Assuming that these costs may be as much as $8.5 million, the Federal share limit would be $66.5 million. Participating States will be advised of the spending limitation and informed that once the spending limit is reached, further Federal matching payments will stop and the State will be responsible for the total cost of the Medicaid IMD excluded services.

A mechanism is needed to track predicted and observed payments, to help CMS establish funding limits for each State and assist CMS in providing information to the States when they are near their funding limit. This mechanism (See Attachment B) will help CMS to ensure that the Federal Medicaid reimbursement is halted before the total funding limit is reached.

As part of their Demonstration application, States will be required to provide the names of the psychiatric facilities they selected to participate in the Demonstration with information about the number of psychiatric beds, cost per bed per day, average length of stay, the estimated number of emergency psychiatric adult Medicaid patients expected to be admitted each year at these facilities, and the estimated Medicaid costs. At the beginning of the Demonstration, these figures and estimates will be used to determine the 3-year limitation for the number of patients and Federal share payments for each State. These estimates can be updated each quarter based on the actual claims submitted by the States. In this way, both CMS and the States will be able to assess their cumulative expenditures relative to the Demonstration funding limitation.

As the cost estimate is re-calibrated each quarter based on actual patient census and cost experience, a mechanism can be used to reallocate spending limits to distribute funds equitably across the States. As an example, in Attachment B, Table 1, the estimated 3-year Federal share amount (column 6) is divided by the average cost per day per bed (column 2) to yield an estimate of the 3-year total number of inpatient days for each State (column7). The next column in Table 1 lists the ratio per-State of the inpatient day total to the total across all States or each State's

proportion to the whole (column 8). Multiplying these percentages against the $66.5 million Demonstration spending limit yields an apportioned 3-year Federal match spending limit for each State (column 9). Dividing that amount by the cost per bed per day provides the corresponding apportioned 3-year inpatient day limit (column 10).

During the Demonstration, some States may experience higher or lower than expected patient admissions. If the initial spending limits remain, some States could reach their funding limits early and end participation, while others continue for 3-years without reaching their funding limits. Thus it would be possible to have both left over funds and also States that ended participation for lack of funds. The mechanism to reallocate expenditure limits will ensure the equitable distribution of Federal matching funds, give each State the fullest opportunity to participate in the Demonstration and help to inform CMS and the States as to when funding will end.

B.2 Purpose and Use of the Information

B.2.1 State Application Proposal

The statute requires that a State seeking to participate in this Demonstration project shall submit an application that includes such information, provisions, and assurances necessary to assess the State's ability to conduct the Demonstration as compared with other State applicants.

B.2.2 State Reporting

As a condition for receiving payment under this Demonstration, a State shall be responsible for collecting and reporting information to the CMS about the conduct of the Demonstration in the State for the purposes of providing Federal oversight and the evaluation of the Demonstration. This information will include regular reports by institution about patient admissions and discharges, their diagnoses, time to stabilization, and lengths of inpatient stay. The State is also required to cooperate with the CMS evaluation team and assist in the collection of information necessary to evaluate the Demonstration.

B.2.3 CMS Evaluation

The CMS is required to conduct an independent evaluation to determine the impact of the Demonstration on the functioning of the health and mental health service system within the participating States and individuals enrolled in the Medicaid program. The evaluation shall include: (1) An assessment of the Demonstration in relation to access to inpatient mental health services under the Medicaid program including average lengths of inpatient stays and emergency room visits; (2) An assessment of discharge planning by participating hospitals; (3) An assessment of the impact of the Demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care); and (4) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the Demonstration project as compared to those admitted to these same facilities through other means. CMS is also required to submit to Congress a recommendation as to

whether the Demonstration project should be continued after December 31, 2013, and expanded on a national basis.

B.3 Use of Information Technology

States currently electronically collect the required information for this Demonstration and will submit information electronically to CMS. The information collection will not require a signature from the participating States.

B.4 Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

B.5 Small Businesses

This information collection does not impact small businesses or other small entities.

B.6 Less Frequent Collection

The statute requires that a State seeking to participate in this Demonstration project shall submit an application that includes such information, provisions, and assurances necessary to assess the State's ability to conduct the Demonstration as compared with other State applicants.

B.7 Special Circumstances

There are no special circumstances for this information collection.

B.8 Federal Register/Outside Consultation

The information collection will only occur once in the application proposal voluntarily submitted by State Medicaid Directors. The emergency Federal Register notice with 25-day comment period published on April 8, 2011.

B.9 Payments/Gifts to Respondents

This Demonstration will not require payments/gifts to respondents.

B.10 Confidentiality

No assurance of confidentiality is provided to the participating States, but it is CMS' policy to apply confidentiality for all individual identifying information.

B.11 Sensitive Questions

This Demonstration does not include surveys or individual respondents.

B.12 Burden Estimates (Hours & Wages)

This Demonstration involves the voluntary submittal of one application proposal from a maximum of 54 State Medicaid Directors. The application proposal submittal will only occur once. CMSs estimate is 40 hours and wages totaling $1,600 for States to gather necessary information and to write the application proposal.

B.13 Capital Costs

This Demonstration does not involve capital costs.

B.14 Cost to Federal Government

There is no cost to the Federal government for this Demonstration.

B.15 Changes to Burden

There are no changes to burden for this Demonstration.

B.16 Publications/Tabulation Dates

There are no publications/tabulation dates for this Demonstration.

B.17 Expiration Date

This Demonstration does not include a survey or form.

B.18 Certification Statement

There are no exceptions to the certificate statement identified in Item 19, “Certificate for Paperwork Reduction Act Submissions,” of OMB Form 83-I.

References

42 U.S.C. §1396d , United States Code, Title 42: The Public Health and Welfare, Section 1396d, Definitions, U.S Government Printing Office, January 2003.

42 U.S.C. §1395dd, United States Code, Title 42: Section 1395dd, Examination and Treatment for Emergency Medical Conditions and Women in Labor, [Social Security Act, Section 1867]

Centers for Medicare & Medicaid Services, Medicare State Operations Manual, Appendix V Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Revision 60, July 16, 2010.
http://www.cms.gov/manuals/Downloads/som107ap_v_emerg.pdf

DHHS, ASPE, A Literature Review: Psychiatric Boarding, David Bender, Nalini Pande, Michael Ludwig, The Lewin Group, Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, US DHHS, October 28, 2008 contract number HHS-100-03-0027.

DHHS/HCFA and OIG, Medicare Program; Participation in CHAMPUS and CHAMPVA, Hospital
Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 42 CFR Parts 405 and 489 and 42 CFR Part 1003, Federal Register, June 22, 1994, Sec. 482.12(f),Page 30.

Geller, Jeffrey L., Excluding Institutions for Mental Diseases From Federal Reimbursement for Services: Strategy or Tragedy? Psychiatric Services, Volume 51, pp. 1397-1403, November 2000.

Rosenbaum, Sara, Teitelbaum, Joel, and Mauery, D. Richard, An Analysis of the Medicaid IMD Exclusion, Center for Health Services Research and Policy, Department of Health Policy, George Washington University School of Public Health and Health Services, December 19, 2002,
http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/behavioral_health/reports/IMD%20Report%201202.pdf

Torrey, E. Fuller, Out of the Shadows: Confronting America's Mental Illness Crisis, John Wiley & Sons, New York, 1997.

United States General Accounting Office, EMERGENCY CARE: EMTALA: Implementation and Enforcement Issues, Report to Congress, GAO-01-747, June 2001.

ATTACHMENT A

LEGISLATIVE LANGUAGE

SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—
(1) have attained age 21, but have not attained age 65;
(2) are eligible for medical assistance under such plan; and
(3) require such medical assistance to stabilize an emergency medical condition.
(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.
(c) ELIGIBLE STATE DEFINED.—
(1) IN GENERAL.—An eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).
(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.
(3) SELECTION.—A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.
(d) LENGTH OF DEMONSTRATION PROJECT. — The demonstration project established under this section shall be conducted for a period of 3 consecutive years.
(e) LIMITATIONS ON FEDERAL FUNDING.—
(1) APPROPRIATION.—
(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.
(B) BUDGET AUTHORITY. — Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal government to provide for the payment of the amounts appropriated under that subparagraph.
(2) 5-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

(3) LIMITATION ON PAYMENTS. — In no case may—
(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or
(B) payments be provided by the Secretary under this section after December 31, 2015.
(4) FUNDS ALLOCATED TO STATES.—Funds shall be allocated to eligible States on the basis of criteria, including a State's application and the availability of funds, as determined by the Secretary.
(5) PAYMENTS TO STATES. — The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).
(f) EVALUATION AND REPORT TO CONGRESS.—
(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:
(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.
(B) An assessment of discharge planning by participating hospitals.
(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).
(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.
(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.
(2) REPORT. — Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).
(g) WAIVER AUTHORITY.—
(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.
(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to state wideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.
(h) DEFINITIONS. — In this section:
(1) EMERGENCY MEDICAL CONDITION.—The term ‘‘emergency medical condition’’ means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.
(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term ‘‘Federal medical assistance percentage’’ has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) INSTITUTION FOR MENTAL DISEASES. — The term ‘‘institution for mental diseases’’ has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).
(4) MEDICAL ASSISTANCE. — The term ‘‘medical assistance’’ has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).
(5) STABILIZED.—The term ‘‘stabilized’’ means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.
(6) STATE.—The term ‘‘State’’ has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

ATTACHMENT B

COST ESTIMATE AND MECHANISM TO LIMIT, REALLOCATE AND STOP EXPENDITURES

Demonstration Cost Estimate

The Medicaid Emergency Psychiatric Demonstration mandated under section 2707 of the Affordable Care Act authorizes payment for services in settings that are currently not covered under Medicaid. Congress appropriated $75 million for the conduct of the Demonstration and to pay the Federal portion of Medicaid payment for services provided under the Demonstration. As this is only the Federal portion of the Medicaid payment, States participating in the Demonstration will be expected to pay their portion of the Medicaid payment for these additional services, totaling perhaps an additional $50 million depending on the Federal matching rate, plus the additional administrative costs in implementing the Demonstration.

Although not specifically stated, the statute implies that savings may be achieved under Medicaid by reducing Medicaid expenses associated with less appropriate care in lieu of inpatient admission including those associated with emergency department psychiatric boarding at general hospitals. However, specific estimates of these costs for Medicaid patients age 21 to 64, or for Medicaid patients in general, are not available in the literature.

Important in developing an estimate of the number of eligible patients and cost of providing Medicaid payment for this population is some estimate of the number of Medicaid eligible patients aged 21 to 64 admitted to psychiatric facilities, the average length of stay for these admissions, and the cost per day. The National Association of Psychiatric Health Systems (NAPHS) commissioned an analysis in 2005 to estimate the budgetary impact of modifying the Medicaid institution for mental diseases (IMDs) exclusion. The analysis was performed by the Moran Company and was entitled "Estimating the Budgetary Impact of Modifying the Medicaid 'IMD Exclusion' to Cover Emergency Care: An Update to the 2006-2015 CBO Baseline." To obtain specific information about the target population, the analysis included a survey of 40 non-government psychiatric institutions from among the membership of the NAPHS. The findings from the analysis revealed that approximately 45.5 percent of all psychiatric inpatient days for Medicaid enrollees were the result of emergency admissions required under the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). Of these, 15.5 percent were uncompensated days for Medicaid enrollees aged 21 to 64. The authors reported that this translated into an average of 4.3 uncompensated EMTALA (emergency admission) days for adult Medicaid entitlees per licensed psychiatric bed. Based on this report, multiplying the number of beds in a psychiatric facility by 4.3 will yield an estimate of the number of uncovered Medicaid IMD exclusion days at that facility during a year. Thus, to provide an example, if a psychiatric hospital has 85 beds, the total number of uncovered EMTALA days would be 85 multiplied by 4.3 or 365.5 uncovered days for the year.

The 2008 NAPHS Annual Survey reported that among its membership of private psychiatric hospitals, the average psychiatric impatient length of a stay for adult Medicaid patients is 8 days. Using the example above and dividing the total number of uncovered days by the average length

of stay yields an estimate of the number of uncovered Medicaid patients: that is, 365.5 uncovered days divided by 8 equals 45.7 or approximately 46 patients. Thus, one can estimate that for an 85-bed inpatient psychiatric facility there will be approximately 46 uncovered EMTALA Medicaid admissions during the year.

A list of Medicare-certified psychiatric facilities with 17 or more beds was obtained from the Center for Medicaid, CHIP and Survey & Certification (CMCS). These data are from the CASPER Reporting System. State and other government operated facilities were deleted from the list. The data reported in the list included the number of beds and the average payment per bed per day at each facility. Since there is a limit to Demonstration expenditures, it was decided to construct estimates using information from a selection of States most likely to submit applications. States considered most likely to submit an application, at this writing, were those where the Medicaid director has expressed some interest in participating in the Demonstration and/or States which previously conducted a section 1115 Medicaid waiver program that waived the Medicaid IMD exclusion[1]. In all, 20 States were identified to develop the estimate: Arizona, California, Connecticut, District of Columbia, Delaware, Georgia, Louisiana, Massachusetts, Maryland, Maine, Missouri, North Carolina, North Dakota, New Jersey, New York, Oregon, Rhode Island, Tennessee, Texas, and Vermont.

Below, in Table 1, each State is listed for the average Medicaid psychiatric inpatient per bed per day cost (column 2) and the estimated number of Medicaid IMD exclusion patients per year (column 3) using the aforementioned calculation method[2]. Multiplying the average per bed per day cost by the estimated number of patients and this product by 3 years yields the estimated total Medicaid cost for the 3 years of the Demonstration (column 4). Multiplying this total by the current Federal matching share percentage (column 5) yields an estimate of the total Federal matching amount needed over 3 years (column 6). Thus, if all 20 of these States were included in the Demonstration, the sum total estimated Federal matching payment needed would be over $72 million.

Mechanism to Limit, Reallocate and Stop Expenditures

Section 2707 of the Affordable Care Act requires that payment to States to reimburse the Federal share of Medicaid costs under the Demonstration shall not exceed $ 75 million. Although the statute authorizing the Demonstration has appropriated $75 million to pay the Federal share of Medicaid payments provided under the Demonstration, the statute allows for the use of these funds to pay Federal administrative and evaluation costs for the Demonstration. Assuming that these costs may be as much as $8.5 million, the Federal share limit would be $66.5 million. Participating States will be advised of the spending limitation and informed that once the spending limit is reached, further Federal matching payments will stop and the State will be responsible for the total cost of the Medicaid IMD excluded services.

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[1] CMS discontinued the use of the 1115 waiver program to allow States to conduct demonstrations that waived the requirements of the Medicaid IMD exclusion, the last of 9 such State demonstrations was phased out in 2009.

[2] Per bed per day costs were updated for years 2011 and for years 2012 and 2013 using the average market basket inflation rate for Medicare inpatient psychiatric services (*Federal Register*, Vol. 76, No. 18, 27Jan11, Proposed Rule.)

Referring to Table 1, if all 20 States, in this example, were included in the Demonstration and if all of the estimates are correct, the 3-year total Federal share amount would exceed the Demonstration $66.5 million funding limit. A mechanism is needed to track predicted and observed payments to help CMS, establish funding limits for each State and assist CMS in providing information to the States when they are near their funding limit. This mechanism will help CMS to ensure that the Federal Medicaid reimbursement is halted before the total funding limit is reached.

As part of their Demonstration application, States will be required to provide the names of the psychiatric facilities they selected to participate in the Demonstration with information about the number of psychiatric beds, cost per bed per day, average length of stay, the estimated number of emergency psychiatric adult Medicaid patients expected to be admitted each year at these facilities, and the estimated Medicaid costs. At the beginning of the Demonstration, these figures and estimate will be used to determine the 3-year limitations for the number of patients and Federal share payments for each State. These estimates can be updated each quarter based on the actual claims submitted by the States. In this way, both CMS and the States will be able to assess their cumulative expenditures relative to the Demonstration funding limitation.

As the cost estimate is re-calibrated each quarter based on actual patient census and cost experience, a mechanism can be used to reallocate spending limits to distribute funds equitably across the States. Referring again to Table 1, the estimated 3-year Federal share amount (column 6) is divided by the average cost per day per bed (column 2) to yield an estimate of the 3-year total number of inpatient days for each State (column 7). The next column in Table 1 lists the ratio per-State of the inpatient day total to the total across all States or each State's proportion to the whole (column 8). Multiplying these percentages against the $66.5 million Demonstration spending limit yields an apportioned 3-year Federal match spending limit for each State (column 9). Dividing that amount by the cost per bed per day provides the corresponding apportioned 3-year inpatient day limit (column 10).

During the Demonstration, some States may experience higher or lower than expected patient admissions. If the initial spending limits remain, some States could reach their funding limits early and end participation, while others continue for 3-years without reaching their funding limits. Thus it would be possible to have both left over funds and also States that ended participation for lack of funds. The mechanism to reallocate expenditure limits will ensure the equitable distribution of Federal matching funds, give each State the fullest opportunity to participate in the Demonstration, and help to inform CMS and the States as to when funding will end.

TABLE 1

Estimated Medicaid Payment (Total, State and Federal) Over 3 Years
And an Example of a Mechanism to Set Spending Limits

1	2	3	4	5	6	7	8	9	10
	Avg. $ per bed per day*	Est. IMD Pts in State	Estimated 3-Year Total Medicaid Dollars.*	Fed Share %	Est. 3-Year Fed Share Dollars	Est. 3-Year Num Inpatient Days per State	State % of Total # Pt. Days	Apportioned 3-Year Federal Share Limit	Apportioned 3-Year Inpatient Day Limit
ST									
AZ	$713	197	$3,377,601	66%	$2,229,217	4,734	2.62%	$1,743,125	4,372
CA	$716	1,210	$20,785,821	50%	$10,392,911	29,038	16.08%	$10,691,486	26,815
CT	$700	130	$2,176,441	50%	$1,088,221	3,109	1.72%	$1,144,668	2,871
DC	$700	108	$1,806,175	70%	$1,264,323	2,580	1.43%	$949,932	2,382
DE	$742	109	$1,934,066	53%	$1,025,055	2,606	1.44%	$959,431	2,406
GA	$698	517	$8,647,723	65%	$5,621,020	12,397	6.86%	$4,564,424	11,448
LA	$690	585	$9,689,248	64%	$6,201,119	14,048	7.78%	$5,172,381	12,973
MA	$707	588	$9,984,558	50%	$4,992,279	14,113	7.81%	$5,196,129	13,032
MD	$690	401	$6,641,403	50%	$3,320,702	9,623	5.33%	$3,543,247	8,887
ME	$742	108	$1,914,917	64%	$1,225,547	2,580	1.43%	$949,932	2,382
MO	$701	336	$5,652,587	63%	$3,561,129	8,063	4.46%	$2,968,538	7,445
NC	$725	218	$3,798,984	65%	$2,469,339	5,237	2.90%	$1,928,362	4,836
ND	$742	87	$1,541,508	60%	$924,905	2,077	1.15%	$764,695	1,918
NJ	$690	465	$7,703,372	50%	$3,851,686	11,159	6.18%	$4,108,457	10,304
NY	$686	670	$11,021,145	50%	$5,510,572	16,073	8.90%	$5,918,077	14,843
OR	$742	42	$746,818	63%	$470,495	1,006	0.56%	$370,474	929
RI	$700	95	$1,598,465	53%	$847,187	2,283	1.26%	$840,690	2,109
TN	$691	236	$3,915,071	66%	$2,583,947	5,663	3.14%	$2,085,101	5,230
TX	$695	1,346	$22,438,126	61%	$13,687,257	32,302	17.88%	$11,893,150	29,829
VT	$658	80	$1,264,588	59%	$746,107	1,922	1.06%	$707,699	1,775
Total		7,526	$126,638,619		$72,013,017	180,613	100%	$66,500,000	166,786

Note: Products and sums are rounded to nearest whole number.

* 1 to 3-year cost calculations updated by a 2.8% avg. inflation rate (*Federal Register*, Vol. 76, No. 18, 27Jan11)

Total Federal Dollars Available		Avg. Cost Per Pt Day (for States listed)	Avg. Fed $ per Pt day (for States listed)	Estimated total number of patient days that can be paid for under Demonstration
$66,500,000		$701	$399	166,786

APPENDIX 2
Institutions for Mental Diseases

Section 4390 of the State Medicaid Manual (SMM) lists ten factors to be used cumulatively to determine the facility's overall character as an institution for mental diseases (IMD):

1. The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;
2. The facility advertises or holds itself out as a facility for the care and treatment of individuals with mental diseases;
3. The facility is accredited as a psychiatric facility by the JCAH;
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or by the fact that a large proportion of the patients are receiving psychopharmacological drugs;
5. The facility is under the jurisdiction of the State's mental health authority;
6. More than 50 percent of all the patients in the facility have mental diseases which require inpatient treatment according to the patients' medical records;
7. A large proportion of the patients in the facility have been transferred from a State mental institution for continuing treatment of their mental disorders;
8. Independent Professional Review teams report a preponderance of mental illness in the diagnoses of the patients in the facility (42 C.F.R. 456.1);
9. The average patient age is significantly lower than that of a typical nursing home;
10. Part or all of the facility consists of locked wards.