Medicaid Emergency Psychiatric Demonstration

Demonstration Design and Solicitation

Under the authority of section 2707 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), the Centers for Medicare & Medicaid Services (CMS) is funding the Medicaid Emergency Psychiatric Demonstration, which will be conducted by participating States. This is a 3-year Demonstration that permits participating States to provide payment under the State Medicaid plan to certain non-government 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. Under current law, treatment provided to adults in an institution for mental diseases with more than 16 beds is not reimbursable under Medicaid; this payment prohibition is known as the Medicaid institution for mental diseases (IMD) exclusion.

The Demonstration will assess whether this expansion of Medicaid coverage to include certain emergency services provided in non-government inpatient psychiatric hospitals improves access to, and quality of, medically necessary care, discharge planning by participating hospitals, and Medicaid costs and utilization. CMS must also provide a recommendation to Congress regarding whether the Demonstration should be continued and expanded on a national basis. Focusing on psychiatric emergencies, the Demonstration is also an attempt to explore a potential remedy to alleviate burdens on general hospital emergency rooms from psychiatric patients (sometimes referred to as psychiatric boarding).

State Medicaid Agencies are 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, a description of the Demonstration design and requirements for State participation, and the instructions for preparing an application proposal.

Background

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 usually provided through inpatient admissions to large private or State-funded mental hospitals. At the same time, such 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 not established. As a result, those with more serious mental illnesses were often condemned to years of largely custodial inpatient care. With the advent of a new class of psychotropic drugs in the mid-1950s, in particular the anti-psychotic medication chlorpromazine, it was found that many persons with mental illness 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 civil liberties principle that severe mental illness should be treated in the least restrictive setting feasible (Torrey, 1997).

Federal law had long recognized the primary responsibility of States for funding inpatient psychiatric hospitals. As a result, State and local governments historically 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 (the 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 was concern by Congress that State mental institutions were simply warehouses which furnished no effective treatment, and thus were inappropriate for Medicaid (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.

In 1972, amendments were made to the Act expanding 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 illness, including medical attention, nursing care, and related services (42 U.S.C. §1396d(i)). It is important to note that the payment exclusion does not apply to inpatient treatment for mental illnesses in facilities that are part of larger medical entities that are not primarily engaged in the treatment of mental illnesses (generally tested by whether the majority of the patient population was admitted and treated for reasons other than mental illness), such as general hospitals or skilled nursing facilities.

As part of the Medicare Catastrophic Act of 1988 (Pub.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. The result of these amendments is that Medicaid currently provides mental health treatment coverage for a large percentage of people with Medicaid, but that coverage is excluded for inpatient treatment of adults aged 21 to 64 in any acute or long-term care institutions with 17 or more beds that are primarily engaged in providing treatment for mental illnesses. 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 illness 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 available for emergency services. As a consequence, the Medicaid IMD exclusion may be a contributing factor to psychiatric boarding and recidivism in general hospital emergency departments.

Emergency Medical Treatment and Labor Act (EMTALA)

In 1986, the EMTALA was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 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 with emergency departments 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 a 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 individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC (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 with an emergency department to provide treatment until the individual's condition is stabilized or the individual is transferred to an inpatient facility where the person can be treated until the condition is stabilized.

Stabilization of an emergency psychiatric patient under EMTALA is specifically defined in the CMS State Operations Manual. To paraphrase, psychiatric patients are considered stabilized when they are no longer expressing suicidal or homicidal thoughts or gestures, and no longer require immediate treatment to protect and prevent them from injuring themselves or others. The administration of chemical or physical restraints for the purpose of removing the potential of harm to or by the individual with a psychiatric EMC during the transport to another medical facility is not necessarily considered stabilizing treatment for the EMC if such restraints are a temporary intervention for transport only, rather than part of the individual's emergency treatment plan (CMS, 2010). Therefore, patient restraint, if needed, does not constitute stabilization.

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 so long as the hospital has the capacity to treat the individual. 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 psychiatric admissions in any facility 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 illness.

The combination of these policies can result in psychiatric hospitals rendering uncompensated care to individuals in need of stabilizing treatment for a psychiatric EMC, because psychiatric hospitals are required under EMTALA to accept an appropriate transfer from another hospital of these individuals so long as the hospital has the capacity to provide stabilizing treatment, and because these individuals are not commonly insured by other health plans.

Diversity in Structure and Management of Behavioral Health Care in State Medicaid Programs

There is a large body of research describing how delivery system structure, payment arrangements, and regulations affect mental health care. Significantly, today most people with Medicaid are enrolled in managed behavioral health care plans (MBHC). These arrangements differ along many dimensions; for example whether the MBHC program tracks the benefit design of the State plan, pays its providers on a fee-for-service basis, or imposes utilization management protocols on the delivery system. These differences in behavioral health delivery systems fundamentally affect the impact of any IMD policy changes on cost, quality, and access to mental health care. Thus, these kinds of differences in how States structure their behavioral health care delivery systems should be factors in the selection of States for participation in this Demonstration.

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 health condition is kept in a hospital emergency department for several hours because appropriate mental health services are unavailable. There are a number of factors that contribute to the prevalence of psychiatric boarding including a lack of outpatient resources and treatment coordination, a lack of inpatient capacity which are tied to State general funding issues, and the fact that psychiatric services are relatively unprofitable and often perceived as less of a need. The Medicaid IMD exclusion exists as one more contributing factor to exacerbate the problem.

In the case of more serious mental health conditions requiring inpatient admission, boarding can include inappropriate placement in a setting where specialized services to meet the patients needs are not available (for instance, to a bed on a medical ward or in a skilled nursing facility without psychiatric expertise), 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.

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).

Medicaid Emergency Psychiatric Demonstration Legislation

In section 2707 of the Affordable Care Act, Congress authorized a 3-year demonstration to study the effects of allowing Medicaid payment for the inpatient stabilization of mental health related problems for individuals ages 21 through 64 in non-government psychiatric hospitals that are subject to the requirements of EMTALA. When patients with these serious mental health conditions are treated in general hospital emergency room settings this can contribute substantially to increased costs resulting from psychiatric boarding while the patient awaits appropriate stabilization and treatment.

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.

Medicaid Emergency Psychiatric Demonstration Design

Section 2707 of the 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 who 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 publicly owned or operated and is subject to the requirements of EMTALA.

Demonstration Requirements

There are several requirements stated or implied by the statute that guide the implementation and operation of the Demonstration.

State Participation

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).

State Selection

States submitting applications to participate in the Demonstration will be selected on a competitive basis based on their responses to the application subject areas and taking into consideration a number of factors including the availability of various types and combinations of beds in the State (e.g., in general hospital psychiatric units, private psychiatric hospitals, and public mental hospitals), the level and types of investments in community-based behavioral health services by the State (e.g., assertive community treatment (ACT) programs, mobile treatment teams, and partial hospitalization programs), and the design of the State's Medicaid program itself (including the degree of specialized managed behavioral health care, State choices about including optional populations, use and design of the rehabilitative services option). The selection will also include factors necessary to achieve an appropriate national balance in the geographic distribution of the Demonstration as well as representation of States with varied approaches to behavioral health care delivery, payment, and benefit design.

Furthermore, the States selected shall be limited in number to ensure sufficient funds are available in each participating State to enable an informative assessment of the effect of waiving the IMD exclusion for emergency care in private psychiatric hospitals in those States.

Demonstration Management

The 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 section 2707 of the Affordable Care Act.

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 illness, including medical attention, nursing care, and related services (Section 1905(i) of the Act, 42 U.S.C. 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 Act of the Emergency Medical Treatment and Active Labor Act or EMTALA (Section 1867 of the Act, 42 U.S.C. 1395dd), i.e., a Medicare participating institution having an emergency department.

(3) Not be publicly owned or operated.

Note:
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 individuals eligible under the authority of section 1115 of the Act; 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 to individuals meeting these criteria who receive medical assistance under the State's Medicaid fee-for-service program Individuals in managed care plans whose eligibility and payment for inpatient psychiatric services is Medicaid fee-for-service (i.e., carved out) are also eligible for this Demonstration. In addition, this Demonstration may include individuals enrolled in managed care plans covering inpatient care as long as the State demonstrates in its application how it will ensure that Demonstration payments to the State for services under the Demonstration do not duplicate payments to the State for the same services under the capitation rates paid to managed care organizations. 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.

Patient Administration

As stated in the Affordable Care Act, 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. Consistent with section 2702 of the Affordable Care Act, this process must be initiated 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 behavioral health.

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.

Payment to Participating Institutions

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

Mechanism to Limit, Reallocate, and Stop Expenditures

States selected to participate in this demonstration shall be limited in number to ensure that sufficient funds are available for each participating State to enable an informative assessment of the effect of waiving the IMD exclusion for emergency care in private psychiatric hospitals in those States.

A mechanism will be instituted at the beginning of the Demonstration to track predicted and observed expenditures under the Demonstration in order to establish funding limitations for each State based on the expected number of admissions under the Demonstration, and to help ensure that the Federal funding limit is not exceeded. The estimates and funding limits for each State will be based initially on the patient census estimates provided by participating States before the Demonstration begins. Thereafter, the actual patient census and payments to each State will be continuously monitored, funding limits for each State will be adjusted as needed, and funding will be terminated when the spending limit for each State is reached.

This mechanism will be used to provide CMS and the States with some indication of the distribution of funding in relation to the funding limits based on real and anticipated patient admissions and costs. This mechanism may be used also to reset or adjust spending limits, when real expenditures vary appreciably from the expenditure estimates, to help ensure that all States are allowed to participate the full 3 years of the Demonstration without exceeding the total funding limitation.

State Reporting

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

Statutory Waiver Authority

Under section 2707 of the 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(a)(10)(B) relating to comparability, to the extent necessary to carry out this Demonstration. Please note that section 2707(g)(2) of the Affordable Care Act contains a drafting error; the law refers to “1902(1)(10)(B) (relating to comparability).” No such

section 1902(1)(10)(B) exists in the Social Security Act; rather, we concluded, based on the parenthetical "relating to comparability" that Congress intended to refer to section 1902(a)(10)(B) of the Act. Thus, section 2707 of the Affordable Care Act 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.

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 on 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. Where managed care patients are included in the Demonstration, the State will be expected to provide patient level information sufficient to assess access to care and the treatment arrangements under managed care. 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.

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.