National Association for Behavioral Healthcare

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SUBMITTED VIA: www.regulations.gov

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

12 August 2019

Re: CMS–6082–NC: Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork RIN 0938–ZB54.

Dear Ms. Verma:

As an association representing behavioral healthcare provider organizations and professionals, the National Association for Behavioral Healthcare (NABH) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) request for information (RFI) on "Reducing Administrative Burden To Put Patients Over Paperwork" published in the Federal Register on June 11, 2019.

Founded in 1933, NABH represents and advocates for behavioral healthcare provider systems that are committed to delivering 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 that own or manage more than 1,000 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral health divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. These providers deliver all levels of care, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

Regulatory Burden on Inpatient Psychiatric Care

Inpatient psychiatric facilities offer critical support to Americans with severe mental health needs and help patients through times of crisis until it is safe for them to continue treatment in the community. Behavioral healthcare providers also face a heavy regulatory burden. Reducing those burdens would improve patient access by freeing up inpatient psychiatric facilities' time, financial resources, and, in certain cases, beds. In March, NABH released *The High Cost of Compliance: Assessing the Regulatory Burden in Inpatient Psychiatric Facilities*, a first-of-its-kind report that quantifies the regulatory costs that inpatient psychiatric care providers incur.

That report found that only three regulatory areas— B-tag requirements, ligature risk requirements and the *Emergency Medical Treatment and Labor Act* (EMTALA) —impose an average annual cost of $1.7 billion on America's inpatient psychiatric facilities. Per year, this translates to an average of just under $1 million per facility, or more than $18,000 per licensed psychiatric bed.

Meanwhile, the combined cost of all three regulatory areas amounts to approximately 4.8 percent of an inpatient psychiatric facility's revenue for inpatient psychiatric services. This is a substantial percentage for facilities that have an average net operating margin of negative 5 percent, particularly when many of these regulatory areas contribute little to ensuring high-quality care.

In CMS' RFI, that the agency notes the continued goal of CMS "is to eliminate overly burdensome and unnecessary regulations and sub-regulatory guidance in order to allow clinicians and providers to spend less time on paperwork and more time on their primary mission—improving their patients' health." This is where CMS' goals aligns with those of patients and providers.

Of the three areas identified in our regulatory report, this letter focuses on B-tag requirements. Please see our full report, included with this letter, for more detailed information about B-tags, ligature risk and EMTALA.

Special Conditions of Participation and B-Tags

Inpatient psychiatric facilities must satisfy the Conditions of Participation (CoP) that apply to all general hospitals, as well as additional CoP that address psychiatric patient evaluations, medical records, and staffing. CMS has issued 60 pages of interpretive guidance regarding the psychiatric hospital CoP, in which the agency defines 60 distinct compliance elements (referred to as B-tags), one or more for each CoP. These rules are intended to serve the important goal of ensuring patient safety and high-quality care. However, some of these requirements are now outdated. In addition, many surveyors apply these criteria indiscriminately in the field, exposing providers to unpredictable citations and requiring costly alterations in their procedures, equipment, and facilities.

CMS issued the CoP in 1966 and the interpretative guidance in the 1980s, and the agency has not meaningfully updated the rules and the guidance for psychiatric patient evaluations, medical records, and staffing since then. As enforced today, the B-tags produce frequent citations and impose large costs on providers, mostly through low-value documentation requirements.

Of the COP's 60 individual B-tags, we focus here on two sets of B-tags that are particularly problematic: requirements related to documentation in the patient's medical record, and requirements related to minimum qualifications for certain director-level administrative staff. Taken together, the compliance costs for these two sets of B-tags amount to 1.8 percent of inpatient psychiatric care spending, imposing approximately $625 million in costs every year on America's psychiatric facilities.

Documentation in the Patient's Medical Record

Every hospital—psychiatric or general acute— is required to maintain a comprehensive medical record for each patient that receives care. CMS goes a step further for inpatient psychiatric facilities, using the B-tags to specify numerous details that must be documented in precise ways. Notably, the clinical staff must draft an "individualized treatment plan" for each patient with elements such as the patient's strengths and weaknesses, short- and long-term goals, and planned therapeutic interventions. The plan must be updated periodically with "progress notes" that connect treatment results back to the goals listed in the plan. These requirements may sound reasonable, but the level of detail and frequency of the updates required are no longer appropriate due to seismic shifts in the model of inpatient psychiatric care.

When the psychiatric hospital CoP were first issued in the mid-1960s—and when the current version of the B-tag guidance was issued in the mid-1980s—many psychiatric inpatients remained hospitalized for months or even years, and occasionally languished with only minimal medical attention. Today, the average length of stay at an inpatient psychiatric facility is measured in days, not months. Multidisciplinary teams of clinicians communicate frequently with patients and with each other. Often, the care team's goal is to stabilize inpatients so they can return safely to the community as soon as possible and continue treatment in an outpatient setting. Therefore, clinicians must now gather the same amount of documentation that they once had weeks or months to produce.

For example, Tag B121 specifies that a treatment plan should list patients' short- and long-term goals, but the interpretive guidance expressly states that in a "short-term treatment" scenario, "there may be only one timeframe for treatment goals." Notwithstanding CMS' clear direction in the interpretive guidance, many surveyors expect to see multiple short- and long-term goals, irrespective of the patient's expected length of stay. This leads to treatment plans that focus on patient-identified goals such as "patient will focus on three new ways of coping with his boss," rather than more substantive movement toward discharge criteria.

Another surveyor practice that increases the paperwork burden for hospitals is when surveyors reject using stock language in the treatment plan, even if a care pathway defines clinician roles that do not meaningfully vary from patient to patient (e.g., psychiatrists prescribe medications, nurses administer medications, social workers assist with discharge planning). Clinicians therefore must spend time crafting highly tailored, free-text plans and progress notes. Often, these documents must be written by hand because many freestanding psychiatric hospitals do not have electronic health records (partly, because they were excluded from the $38 billion Incentive Program that CMS established in 2011). This approach is out of step not only with standard practice in non-psychiatric disciplines, but also with the medical industry's trend toward appropriate use of check boxes and standardized language, which saves clinicians time and, when contained in an electronic record, makes the data more searchable, analyzable, and portable.

Qualifications for Certain Director-Level Administrative Staff

Several B-tags require psychiatric facilities to appoint various director-level positions. We focus here on the director of nursing, who must be either: 1) "a registered nurse who has a master's degree in psychiatric or mental health nursing" or an equivalent degree from an accredited nursing school, or 2) a person who is otherwise "qualified by education and experience in the care of the mentally ill." Even though CMS regulations allow for a nursing director who is "qualified by education and experience," some agency surveyors reveal a clear preference for specific academic credentials. In one recent example, a surveyor questioned the qualifications of a director who had a Master of Science in Nurse Administration and more than three decades of work experience in psychiatric settings, plus certifications and continuing education coursework germane to psychiatric care.

This approach contradicts present-day realities in two ways. First, candidates with a master's degree in psychiatric nursing are in short supply. Many individuals who possess such a degree become advanced practice clinicians, rather than hospital administrators. Second, advanced practice nurses may gain years of experience working in psychiatric facilities even if they do not have a degree in psychiatric nursing. Moreover, a registered nurse with psychiatric experience can make an excellent director of nursing, especially if the nurse holds a bachelor's degree in a relevant subject such as hospital management.

Conclusion

Adopting less burdensome requirements would benefit the healthcare system overall by reducing unnecessary costs and by bringing greater stability and predictability for providers as they navigate the regulatory environment. In addition, patients may benefit as clinicians are able to shift more of their attention—and facilities are able to shift more of their resources—away from compliance for compliance's sake and toward initiatives that meaningfully contribute to safe, high-quality care. We recommend that CMS take the following steps:

- Convene a commission with representation from inpatient psychiatric providers to review the B-tags and determine whether some—or all—of these requirements should be revised or discarded.

- Emphasize to surveyors that psychiatric facilities—like general hospitals—may achieve compliance by adopting reasonable approaches to treatment plans, progress notes, and patient evaluations that are appropriate for the facility's patient populations and operations. Areas of particular concern to psychiatric facilities include the following:

    - The precise components of patient evaluations should be determined by psychiatric providers, not prescribed through B-tag survey "probe" questions.

- Providers should not be required to:
  - Identify in advance each member of a patient's treatment team by name and discipline;
  - Include "individualized" descriptions for every clinician's role and every treatment at every stage; or document "assets and deficits" or short and long-term goals for all patients using specific formats;
  - Underscore to surveyors that a director-level positions may be designated based on competence in lieu of a specialized master's degree.

We look forward to continuing our work with you to help identify other opportunities for CMS to maintain flexibility and efficiency in the Medicare program through regulatory, sub-regulatory, policy, practice, and procedural changes.

If you have questions, please contact me directly at 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs Scott Dziengelski at 202-393-6700, ext. 115.

Sincerely,

Mark Covall
President and CEO