



Psychiatric
Emergency
Services

**IMD/
EMTALA ACTION CAMPAIGN**

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EXECUTIVE SUMMARY

The Medicaid Psychiatric Hospital Fairness Act of 2003

H.R.3363 / S.1771

(January 1, 2004)

OVERVIEW

On October 22, 2003, identical versions of the *Medicaid Psychiatric Hospital Fairness Act of 2003* were introduced by Reps. Jim McCrery (R-LA) and Tom Allen (D-ME) in the House (H.R.3363) and Sens. Olympia Snowe (R-ME) and Kent Conrad (D-ND) in the Senate (S.1771).

The proposal addresses the shortage of inpatient psychiatric care and resolves a conflict in Federal law. It would allow Medicaid reimbursement for adult Medicaid patients who are served under the **Emergency Medical Treatment and Labor Act (EMTALA)** for psychiatric hospitals. General hospitals now receive reimbursement for Medicaid-eligible patients, but reimbursement is not provided to psychiatric hospitals serving adult patients (ages 21-64) under the **Medicaid Institution for Mental Disease (IMD) exclusion**.

Under EMTALA, both general and psychiatric hospitals are required to stabilize any patient who comes to an emergency room in a health crisis regardless of ability to pay. Stabilization of psychiatric emergencies often requires admission to ensure that patients are not a danger to themselves or others. Shortages of inpatient psychiatric beds at state psychiatric hospitals and general hospitals result in patients being routinely transferred from general hospitals to psychiatric hospitals or coming directly to the hospital for emergency care.

SUPPORT FOR THE BILL

The measure is supported by:

- the **National Alliance for the Mentally Ill (NAMI)**, which represents 210,000 consumers and family members of those with serious mental illnesses as well as 1,200 affiliate organizations,
- the 38,000 physician members of **the American Psychiatric Association (APA)** and the patients they serve,
- the **National Association of County Behavioral Healthcare Directors (NACBHD)**, which deliver mental health service in about half of the states,
- the 5,000 members of the **American Hospital Association (AHA)**, which represents general and specialty hospitals, and
- the **National Association of Psychiatric Health Systems**, which represents more than 300 non-public psychiatric hospitals and psychiatric units of general hospitals.

These organizations believe that emergency room and short-term inpatient care for psychiatric illnesses should be an integral component of community-based care as it is for other diseases. They support the *Medicaid Psychiatric Hospital Fairness Act* that will allow both general and psychiatric hospitals to receive Medicaid reimbursement for patients who receive care under the *Emergency Medical Treatment and Labor Act*.

IMD

The **Institution for Mental Disease (IMD)** exclusion, enacted in 1965, was designed to prevent states from transferring financial responsibility for long-term care patients in state mental institutions to the Medicaid program and prohibits Medicaid payments for those in an IMD. Although non-public psychiatric hospitals provide services comparable to general hospitals, they are still considered IMDs. Medicaid eligibility is not lost to adult patients (ages 21-64) in IMDs; rather, providers are unable to claim reimbursements for these patients.

The delivery of mental health services has changed dramatically as new diagnostic tools, treatments, and medications have become available. In addition, states have drastically reduced access to public inpatient care. Today, non-public community psychiatric hospitals serve as the safety net for many who have serious mental illnesses, and the average length of stay is very short.

EMTALA

The ***Emergency Medical Treatment and Labor Act (EMTALA)***, enacted in 1985, requires any hospital that receives Medicare funding to:

- treat all patients who come to the emergency room and are in “an emergency medical condition” *that manifests as acute symptoms of*

sufficient severity, including severe pain, such that the absence of immediate medical attention could place the individual's health in serious jeopardy.

- not delay examination and/or treatment to inquire about the patient's insurance or payment status.
- provide an appropriate medical screening evaluation to all patients.
- stabilize identified medical conditions or provide an appropriate medical transfer.

The Centers for Medicare and Medicaid Services adopted standards for **stabilization of psychiatric patients** in the 1998 revisions to the *State Operations Manual*. Federal guidelines defined "stable" as "when a patient is no longer considered to be a threat to him/herself or to others."

WHY IS THIS BILL NEEDED?

The President's New Freedom Commission on Mental Health identified the **lack of acute care** as a serious concern after reviewing state and local reports and listening to testimony from consumers, family members, and providers. The Commission noted that many communities are experiencing severe problems with access to short-term inpatient care – with some areas reporting that the shortage has risen to crisis proportions. The result is that many emergency rooms are overwhelmed with psychiatric patients with an emergency medical condition who have nowhere to go. In addition, uncompensated care is rapidly increasing in many non-public community psychiatric hospitals across the nation.

The advent of new medications coupled with outpatient treatment for psychiatric illness has been important factors in de-institutionalization of those who have serious mental illnesses (SMI). Most individuals with mental illnesses can live and work independently in the community.

However, some individuals find that their mental illness is chronic, debilitating, and life-threatening – even under the best of circumstances. Emergency and short-term inpatient care is essential for adults with SMI who are suicidal, homicidal, or gravely in danger of losing their lives.

Helping someone who is suffering from serious mental illness such that they are considered to be a threat to themselves or others is not the same as addressing a physical injury. Patients with SMI who enter the hospital under EMTALA may require 24-hour care and intensive treatment before they can access ambulatory or outpatient services or support. Today, hospitals provide short-term stabilization for those who are deemed by a medical professional to be a danger to themselves and others or in a crisis situation. Adults, who are sick enough to be admitted to inpatient care, generally have very brief stays. Without such short-term care, many SMI adults are so ill that they are not able to access outpatient care.

Today, the pressure to cut costs under managed care and reduce public health spending has affected mental health services as it has other health services. As a result of these and other factors, there has been a significant decline in access to acute care from 1992 to 2000 with state hospitals declining by 29%, psychiatric

hospitals declining by 38%, and general hospital units declining by 14%. In many areas, the shortage of acute psychiatric care is at the crisis level.

SUMMARY

EMTALA requires assessment and stabilization of patients manifesting an emergency medical condition, while the IMD exclusion prohibits Federal matching payments for adult Medicaid patients who enter the hospital under EMTALA. The *Medicaid Psychiatric Hospital Fairness Act of 2003* will provide greater access to short-term, affordable, and effective care for those whose psychiatric emergency presents a danger to themselves and others. It will also resolve a conflict in Federal law and allow both general and psychiatric hospitals to receive payment for services rendered to Medicaid patients under EMTALA.

FOR MORE INFORMATION

Please contact the National Association of Psychiatric Health Systems (NAPHS) at 202/393-6700. Contact either NAPHS Executive Director Mark Covall (ext. 100 or Mark@naphs.org) or NAPHS Director of Government Relations Kathleen Sheehan (ext. 103 or Ksheehan@naphs.org).