National Association of Psychiatric Health Systems

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June 13, 2008

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS–1390–P; RIN 0938–AP15
Proposed Rule (Vol.73, No.84), April 30, 2008:
"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Proposed Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Proposed Collection of Information Regarding Financial Relationships Between Hospitals and Physicians"

Dear Mr. Weems,

The National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule (CMS-1390-P) published in the April 30, 2008, *Federal Register* on "Proposed Changes to the Hospital Inpatient Prospective Payment System."

Our comments will focus specifically on a section within the proposed rule highlighting proposed policy changes relating to the requirements for furnishing hospital emergency services under the ***Emergency Medical Treatment and Labor Act of 1986*** **(EMTALA)**.

ABOUT NAPHS

As an association representing behavioral healthcare provider organizations and professionals, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, and adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 600 psychiatric hospitals, general hospital

psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care.

EMTALA COMMENTS

We want to bring to your attention several concerns that have been raised by psychiatric hospitals and behavioral healthcare services within general healthcare systems relative to proposed changes in the EMTALA requirements.

Proposed changes relating to applicability of EMTALA requirements to hospital inpatients.

As one of several changes related to the *Emergency Medical Treatment and Labor Act* (EMTALA), CMS proposes to revise EMTALA so that when an individual covered by EMTALA is admitted to a hospital as an inpatient and remains unstabilized with an emergency medical condition (EMC), a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual (assuming the transfer is appropriate and the receiving hospital has capacity to treat the individual).

We strongly object to this proposal. NAPHS maintains that this proposal both represents a substantial change in EMTALA policy and contradicts the current regulations related to the non-applicability of EMTALA to inpatients (42 CFR 489.24 (d)(2)(i)). Current regulation states that once an individual with an EMC is admitted as an inpatient in order to stabilize the EMC, the hospital has satisfied its EMTALA obligations to that individual. As CMS has explained in the past, once an individual becomes an inpatient, he or she has the full protection of the Hospital Conditions of Participation (CoPs). The extension in the proposed rule imposes an EMTALA obligation on any hospital with specialized capabilities that might be called to accept the transfer of an inpatient from another inpatient setting.

The proposed expansion of the applicability of EMTALA to inpatients reportedly emerged from discussion that took place at the EMTALA Technical Advisory Group (TAG) meeting, which NAPHS staff attended. In its 30-month life, the TAG considered any number of substantive issues. The TAG routinely discussed issues, referred them to sub-committees for further research and recommendations, and then re-considered them as a large group before acting on them. Only after this process had been completed (often over several meetings), was a vote taken and a recommendation sent forward.

The idea that EMTALA obligations might be expanded to include inpatients was introduced by one member, near the end of the term of the TAG, and was not a logical consequence of the discussion to date. The topic of post-admission transfers had never been identified as a problem in any of the discussions that preceded its introduction. The topic provoked intense and confusing discussion without adequate time for the suggestion to be fully understood by the TAG members, to be considered by the subcommittee, or to be returned to the TAG for further discussion and thoughtful recommendation.

We were very surprised to see this highly controversial recommendation included in the proposed rule. Besides the fact that it contradicts the common understanding of the scope of EMTALA, it also introduces many potential problems. From the perspective of the behavioral health field, it raises concern that patients could be subjected to significant and potentially unnecessary transfer between facilities. We understand our responsibility to comply with the Medicare Conditions of Participation regarding transfer. However, we reject any proposal that could lead to more (and perhaps arbitrary) transfers than are absolutely necessary for the care of beneficiaries. In addition, we do not feel the proposed amendment to 489.24(f) fairly represents the recommendation of the TAG.

RECOMMENDATION: We recommend that the proposal to revise 489.24(f) extending EMTALA to include inpatients **be deleted** from the proposed rule because it is contradictory to the current understanding of the regulation, has not been carefully vetted, and is unnecessary.

Shared/community call.

CMS proposes that a facility may, as part of its obligation to have an on-call list, participate in a community call plan to provide on-call coverage for an area. This plan would need to be a formal one and based on the assessed needs of the community. NAPHS supports this recommendation because it provides a structure whereby patients experiencing mental health emergencies could be provided with the most efficient access to specialty services. Given the shortage of psychiatrists and other mental health professionals, it may be impossible for each hospital in a given geographic area to provide stabilizing treatment of psychiatric patients with emergency medical conditions. By developing a community system, facilities with specialty services could be designated as the on-call facility, thereby increasing access to the appropriate services for patients.

RECOMMENDATION: NAPHS supports the proposal of the EMTALA TAG to permit "community call" systems to be established for specialty care purposes. The list of elements required in the proposed rule to devise a formal community call plan is extensive. We recommend that the requirements be clear but not overly burdensome.

Additional areas in which CMS is seeking public comment.

CMS is seeking public comment on whether the EMTALA obligation should apply in the case of an individual who has been admitted to a hospital, achieved a period of stability, and is then in need of specialized care available at a hospital with specialized capabilities. Consistent with our position on the extension of EMTALA to inpatients, we do not think a period of stability followed by instability should be a reason for imposition of EMTALA obligations on a receiving hospital.

CMS requested public comment on whether a state or local agency with responsibilities for the development of a formal community call plan should be required to approve the plan. We feel the responsibility for approval of the plan should be vested with the participating healthcare organizations and not require the approval of a public agency.

CONCLUSION

Thank you for your consideration of our comments. We look forward to continuing to work with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) to ensure that Medicare beneficiaries continue to have access to necessary mental health services.

Sincerely,

Mark Covall
Executive Director