Texas Hospital Association

1108 Lavaca Street, Suite 700, Austin, Texas 78701
512/465-1000
www.tha.org

May 17, 2021

Via Email: MCDmedicalbenefitspolicycomments@hhsc.state.tx.us

Re: Draft Policy, Inpatient Psychiatric Services

To Whom It May Concern:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching, specialty, and psychiatric hospitals, the Texas Hospital Association is pleased to submit these comments on the Draft Policy related to Inpatient Psychiatric Services. THA appreciates the HHSC's commitment to an open and transparent policy-making process. THA members continue to evaluate the impact of the draft policy and we will provide additional information to HHSC as it becomes available. Our comments on the draft policy are as follows:

Coverage of Court-Ordered Services

We appreciate the common-sense approach to payment for services described in Section 8 of the draft policy. There are, however, some potential problems with the required documentation that must be submitted as described in section 72.1. That section requires the provider to submit a copy of the court order signed by the presiding judge or magistrate "that includes the statute under which the court is ordering services to determine incarceration status of the person." While we imagine that most court orders will specify the section in the Code that the order is based on, the underlined language would be problematic if the order itself does not contain that statutory reference.

More significantly, section 8.1 applies to services provided under emergency detentions, and specifically includes only an emergency detention "ordered by a judge or magistrate pursuant to Texas Health and Safety Code §§573. 011-573.026." There are two problems with this section. First, we believe payment should also apply if the emergency detention is initiated by a peace officer under §573.001. Hospitals have the same obligation to screen and treat a person whether the detention is under a warrantless detention by a peace officer or pursuant to a warrant issued by a judge or magistrate, and payment should therefore apply to the peace officer-initiated detentions. Second, to avoid unintended consequences or payment disputes, we believe the references in this section should be to a "warrant" or perhaps "order or warrant", since "warrant" is the term used in section 573.012 to describe the action by a judge or magistrate to detain a person under that subchapter.

Requirement of Joint Commission Accreditation

The draft policy requires psychiatric facilities to be accredited by the Joint Commission. We understand this comports with the licensing rule for inpatient psychiatric facilities, but we believe the rule is outdated and unnecessarily limits the accreditation options for psychiatric facilities. Specifically, in July 2020, DMV GL Healthcare was granted deeming authority for Medicare participation by the Centers for Medicare and Medicaid

Services, and other organizations could be approved in the future. We believe a better approach is to state in the policy that an inpatient facility must be accredited by an organization that has been granted deeming authority by CMS for participation in Medicare, without reference to specific organizations.

Changing the term "treatment" plan to "recovery" plan

We note that the reference in Section 17.2 to the required individualized "treatment" plan has been changed to "recovery" plan. While this wording change may seem like a minor issue, it actually could be quite a significant administrative burden for facilities that have an electronic health record that has multidisciplinary "treatment" plans located in multiple notes and places in the EHR. Additionally, CMS, The Joint Commission, and DNV Healthcare all reference multidisciplinary treatment plans in their accreditation requirements. See for example 42 C.F.R. sec. 482.61(c). Without knowing how stringent the specific language around "recovery" plan will be relied on for payment, we are concerned that this change will have an unintended and potentially significant impact on payment if the references in the EHR do not match the language used in the payment policy.

Non-coverage for substance use disorders without comorbid other mental health disorder

We note that the policy of excluding coverage for persons with a single diagnosis of a substance use disorder, as classified in the current edition of the APA's DSM, is contained in the draft policy. Limiting access to services to only those individuals with a co-occurring psychiatric condition is contrary to the well-established and well-recognized role of intervention and treatment of substance use disorder. As CMS noted in 2017, rates of drug overdose deaths have continued to increase rapidly over the past fifteen years, and the rise in prescription and illicit opioid abuse has been the primary driver of this increase.[1] In 2015, the rate of drug overdose deaths was more than 2.5 times the rate in 1999 with deaths from heroin overdoses triple the rate in 2010, and more recently, an influx of illicitly made fentanyl and fentanyl analogs has fueled a substantial increase in synthetic opioid overdose deaths.[2] The term "opioid epidemic" has become commonplace and is accurate. The exclusion of individuals who only have a single SUD diagnosis eliminates from coverage many individuals who could benefit from access to care and who are in danger of themselves becoming in need of other covered services as their SUD goes unaddressed. We urge the agency to reconsider this limitation on coverage for SUDs and allow coverage of single-diagnosis individuals. If the limits on coverage in the draft policy are based on CMS coverage policy, we urge HHSC to do everything in its power to pursue the appropriate waivers from CMS (see State Medicaid Director Letter cited in footnote 1) to establish coverage for this class of individuals.

Ending the IMD Exclusion

The draft policy reflects current law prohibiting states from using Medicaid to pay for care provided in an institution for mental disease or IMD. As the National Alliance on Mental Illness points out on its website, this is the only part of federal Medicaid law that prohibits payment for the cost of providing medically necessary care because of the type of illness being treated. While we recognize the limitations of this payment policy, we urge HHSC to do everything in its power to end this discriminatory and unequal noncoverage of mental health care.

[1] CMS Letter to State Medicaid Directors (SMD # 17-003, RE: Strategies to Address the Opioid Epidemic), Dated November 1, 2017
[2] Id.

We appreciate your consideration of these comments. Should you have any questions or need additional information, please do not hesitate to contact me at 512/465-1577 or swohleb@tha.org.

Respectfully submitted,

Stephen G. Wohleb
Senior Vice President and General Counsel
Texas Hospital Association