Examining the Centers for Medicare and Medicaid Services’ Final Rule on Emergency Preparedness

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Abstract

This paper explores the Center’s for Medicare and Medicaid Services’ (CMS) final rule on Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers with a focus on a cross comparison single case study of psychiatric care facilities and a large academic medical center. Research for this topic utilized online (internet) scholarly articles, the Centers for Medicare and Medicaid Services’ website, and the CMS final rule as it is posted on the Centers for Medicare and Medicaid Services’ website. Additional information was obtained through the frequently asked questions (FAQ’S) of the CMS website and an interview from a large unnamed hospital in the Chicagoland area. It is expected that large academic medical centers will have the financial fortitude and infrastructure to implement the final rule requirements while psychiatric care facilities will have difficulty with program implementation and development. This paper will also explore the current community mental health programs that support our communities in the United States and their ability to meet the Final Rule requirements. Results for this project will be speculative due to the recency of the final ruling and limited amount of available information on the final rule.

Keywords: Emergency Preparedness, Psychiatric Care,

Examining the Centers for Medicare and Medicaid Services’ Final Rule on Emergency Preparedness in Psychiatric Care Facilities

Summary

In 2016, the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The proposed rule establishes national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and manmade disasters, and coordinate with federal, state, tribal, regional and local emergency preparedness systems ("Emergency-Prep-Rule," 2017). The mandate requires all Participating Providers and Suppliers to establish a comprehensive, consistent, flexible, and dynamic regulatory approach to emergency preparedness. There are 21 new or revised elements for hospitals and critical access hospitals (“Joint Commission issues update to its guidelines for emergency management | FierceHealthcare,” 2017).

Psychiatric Treatment Facilities, Community Mental Health Centers, and Hospitals are three (3) of seventeen (17) types of providers included in this ruling who are required to create and implement such programs. A failure to meet the requirements laid out would result in a decrease of critical Medicare and Medicaid funding or being barred from the program all together. The loss of federal funding would be damaging to the current healthcare system (Firestorm; Jim Satterfield, 2017). Other consequences of being non-compliant with the final rule are corrective action and increased reporting requirements (Firestorm; Jim Satterfield, 2017).

Psychiatric Residential Treatment Facilities and Community Mental Health Centers are two of the seventeen providers covered under the final rule that rely on Medicare & Medicaid as their principal source of funding. These facilities are expected to implement and maintain the requirements of the final rule without any additional federal funding. The local communities where these facilities are located are expected to assist and absorb the cost of developing, implementing, and maintaining the final rule mandates. Medicare and Medicaid reimbursements account for approximately 30-50% of the revenue for hospitals and other healthcare providers (Bristow, 2017). Each hospital and facility will perform a self assessment to evaluate where in the budget the necessary funds will come from to be compliant with the final rule (Bristow, 2017). The benefit of being compliant will only ever be known should a disaster occur (Bristow, 2017).

Hospitals are also impacted by the final rule and are expected to meet the final rule requirements due to existing systems that are already in place. The impact on hospitals to meet the demands of the final rule does not hinge upon the development of an emergency management program but rather lies in the integrating the new requirements into already existing systems, because they already have a program that has been tested, revised, and evaluated by a number of professional and accrediting authorities. Hospitals will also face a financial burden to implement the final rule and will have to rely on community stakeholders, vendors, and other partners in business to make up for the financial deficit (Firestorm; Jim Satterfield, 2017).

Problem Statement

Psychiatric Treatment Facilities, Community Mental Health Centers, and Hospitals are required to meet CMS mandates by November 16, 2017. Psychiatric Treatment Facilities and Community Mental Health Centers will have difficulty implementing the final rule mandates while Hospitals are expected to meet the CMS requirements due to prior mandates.

Objective

This research is intended to identify potential obstacles that psychiatric treatment centers and hospitals will encounter in implementing CMS emergency preparedness requirements. To provide public and private sector awareness of CMS requirements in emergency preparedness at psychiatric treatment centers and hospitals. To provide introductory research and baseline information for future study on the impact of the final rule on these facilities. The final rule is recent in publication and the results for this project will be speculative. The results obtained from this research project can be used to guide other research and policy writing in the future.

Background / Rationale / Significance of Problem

The United States has been challenged by several natural and manmade disasters in the past few decades. The terrorist attacks on September 11, 2001, subsequent anthrax attacks, catastrophic hurricanes in the Gulf Coast States in 2005, flooding in the Midwestern States in 2008, H1N1 influenza pandemic in 2009, extreme tornadoes and flooding in the spring of 2011, and Hurricane Sandy in 2012, our nation’s health security and readiness for public health emergencies have been on the national emergency preparedness agenda (Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; Final Rule, 2016). These events exposed gaps in services provided by healthcare centers and the inability of these facilities to maintain a high quality of patient care due to inconsistent standards and varying levels of preparedness (Centers for Medicare and Medicaid Final Rule 2016, n.d.).

In 2013, The Department of Health and Human Services: Center for Medicare & Medicaid Services (CMS) launched an investigation into emergency preparedness of its Medicare and Medicaid facilities. At the end of the investigation, CMS concluded that the system was not properly prepared for current threats and disasters (Centers for Medicare and Medicaid Final Rule 2016, n.d.). As a result, the organization released its final ruling on Emergency Preparedness Requirements for its Medicare and Medicaid Participating Providers and Suppliers. This ruling concluded that each separately certified healthcare facility have an emergency preparedness program that includes an emergency plan based on a risk assessment utilizing an all-hazards approach (Centers for Medicare and Medicaid Final Rule 2016, n.d.). In response to the emergency preparedness plan various policies and procedures will be developed and implemented (Bristow, 2017). A written communication plan will be developed to include communication inside the hospital or facility, across healthcare providers, and with state and local public health departments (“CMS emergency preparedness rule,” 2017). Training and development programs are required to be put in place and tested on an annual basis through large-scale and tabletop exercises (Bristow, 2017).

The final rule ties a facility’s financial survival to its ability to receive critical third-party national accreditation. Accreditation is achieved when an independent organization (for example, the Joint Commission on the Accreditation of Healthcare Organizations) has reviewed and independently determined the healthcare provider complies with specific standards for safety, quality, or performance. This review typically includes comprehensive formulation and material reviews, testing and facility inspections. Insurance underwriters also review a facility's compliance to the final rule to determine if the facility will continue to be insured. There are no exceptions to the rule and facilities must comply and meet accreditation standards by November 15, 2017. If facilities are unable to meet these standards, they can be fined daily until the final rule standards are met and will not receive Medicare Medicaid funding during that time period (Centers for Medicare and Medicaid Final Rule 2016, n.d.).

The purpose of the rule is to increase patient safety during emergencies by addressing systemic gaps, establishing consistent emergency preparedness regiments across provider and supplier types and establishing a more coordinated response to natural and manmade disasters. According to the investigating committee after reviewing existing Medicare emergency regulatory preparedness requirements, many providers and suppliers have emergency preparedness procedures, but fail to protect during emergencies and disasters at a sufficient level.

Each intuition affected by the rule has different requirements to fulfill but all are required to establish and maintain the four pillars of emergency management: to develop an emergency plan based on an individualized risk assessment of the facility; to develop and implement policies and procedures based on the emergency management plan and risk assessment; to develop a communication plan; and to develop training and exercise programs.

The emergency plan is to be developed using an all hazards approach that considers geographic location, patient population, types, number of patients and other at-risk populations that are impacted in each facility. The policies and procedures developed through the emergency plan should address staff, patients, evacuation, sheltering in place and tracking patients and staff (Centers for Medicare and Medicaid Final Rule 2016, n.d.). The communication plan is expected to follow Federal and State laws while coordinating patient care in the facility, across providers, and with state, federal, public health, and local emergency manager assistance. The communication plan should include all staff, all service contractors, patient physicians, residents and caregivers, partnering hospitals and CAH’s, and volunteers (“CMS emergency preparedness rule,” 2017). Contact information for all staff should be kept in both hard and electronic copy and available to everyone included in the facility’s emergency management plan (“CMS emergency preparedness rule,” 2017). The contact information should be updated with the addition of each new employee as well as all departing employees (“CMS emergency preparedness rule,” 2017). Each facility is required to provide adequate training for all new and existing employees and volunteers. Documentation of training will be kept on file and readily available for review at each facility. The communication plan should also address alternative communication plans should standard means of communication not be available in the form of satellite phones or shortwave radios (“CMS emergency preparedness rule,” 2017).

Literature Review

CMS Final Rule

The Center for Medicare and Medicaid Services (CMS) covers over one hundred million people through Medicare, Medicaid, Health Insurance program, and the Health Insurance Marketplace. Additionally, CMS is tasked with creating high quality health care system by lowering the cost of healthcare while not diminishing the quality of care. On 27 December 2013 CMS published its first Emergency Preparedness Rule in the Federal Register. The rule establishes national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers to plan adequately for both natural and manmade disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. It will also assist providers and suppliers to adequately prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations. The purpose of the rule is to increase patient safety during emergencies by addressing systemic gaps, establishing consistent emergency preparedness regiments across provider and supplier types, and establishing a more coordinated response to natural and manmade disasters. According to the investigating committee after reviewing existing Medicare emergency regulatory preparedness requirements for both providers and suppliers, they found many providers and suppliers have emergency preparedness requirements, but those requirements do not go far enough in ensuring these providers and suppliers are equipped and prepared to help protect those they serve during emergencies and disasters. “We concluded the current emergency preparedness requirements are not comprehensive enough to address the complexities of the actual emergencies” (“CMS emergency preparedness rule,” 2017). The past 17 years have shown how unprepared the United States has been for complex emergencies and disasters. The September 11, 2001 terrorist attacks, the subsequent anthrax attacks, the catastrophic hurricanes in the Gulf Coast states in 2005, flooding in the Midwestern states in 2008, the 2009 H1N1 influenza pandemic, tornadoes, and floods in the spring of 2011, and Hurricane Sandy in 2012, our nation’s health security and readiness for public health emergencies have been on the national agenda.”(Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; Final Rule, 2016)’

The CMS final rule applies to seventeen Medicare and Medicaid providers and suppliers:

1. Hospitals

2. Religious Nonmedical Health Care Institutions (RNHCIs)

3. Ambulatory Surgical Centers (ASCs)

4. Hospices

5. Psychiatric Residential Treatment Facilities (PRTFs)

6. All-Inclusive Care for the Elderly (PACE)

7. Transplant Centers

8. Long-Term Care (LTC) Facilities

9. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

10. Home Health Agencies (HHAs)

11. Comprehensive Outpatient Rehabilitation Facilities (CORFs)

12. Critical Access Hospitals (CAHs)

13. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

14. Community Mental Health Centers (CMHCs)

15. Organ Procurement Organizations (OPOs)

16. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

17. End-Stage Renal Disease (ESRD) Facilities

The CMS announcementrequire a coordinated set of requirements to be established by the various providers governed under the rule. Two major topics covered in the regulation are the development of an emergency preparedness program and specialized provisions dealing with emergency backup power supplies for certain health care facilities ("Emergency Preparedness," n.d.). The emergency preparedness spectrum extends to the public who rely on the various organizations who provide different levels of medical and social wellness care as well as to the staff and physical plant assets which are part of the delivery system. ("Emergency Preparedness," n.d). Each institution affected by the rule have very different requirements to meet compliance but they are all required to establish and maintain the four pillars of emergency management:

1. Develop an emergency plan based on a risk assessment
2. Develop and implement policies and procedures based on the emergency plan and risk assessment
3. Develop a communication plan that complies with both Federal and State laws
4. Develop and maintain training and testing programs, including initial training in policies and procedures.

This final rule was written in good faith and addresses key essentials that are necessary for maintaining access to healthcare services during emergencies but it has many pitfalls about some of the providers and supplies covered under.

For a healthcare organization to participate in and receive federal payment from Medicare or Medicaid programs, one of the requirements is a healthcare organization meet the government requirements for program participation, including a certification of compliance with the health and safety requirements called Conditions of Participation (CoPs) or Conditions for Coverage (CfCs), which are set forth in federal regulations. The certification is achieved based on either a survey conducted by a state agency on behalf of the federal government, such as CMS, or by a national accrediting Third-party organization, such as The Joint Commission on the Accreditation of Healthcare Organization (JCAHO), has been approved by CMS as having standards and a survey process which meets or exceeds Medicare’s requirements. Health care organizations who achieve accreditation through a Joint Commission “deemed status” survey are determined to meet or exceed Medicare and Medicaid requirements ("The Joint Commission," n.d.).

Founded in 1951, JCAHO sees to continuously improve public health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. According to JCAHO’s data base they evaluates and accredits more than 21,000 health care organizations and programs in the United States. The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. To earn and maintain JCAHO Gold Seal of Approval, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years. ("The Joint Commission," n.d.).

The Social Security Amendments of 1972 amended the Medicaid Statute to allow states the option of covering inpatient psychiatric hospitals services for individuals under 21 . Originally, the statute required psychiatric care for individuals under 21 be provided by psychiatric hospitals which are accredited by JCAHO. However, JCAHO indicated that this Federal requirement conflicted with their policy that facilities should seek accreditation voluntarily. In 1984, Congress amended 1905(b), removing the requirement for JCAHO accreditation and adding the requirement the providers of the psychiatric care for individuals under 21 meet the definition of a psychiatric hospital under the Medicare program. In 1990, the Omnibus Budget Reconciliation Act of 1990 provided authority for CMS to specify inpatient settings in addition to the psychiatric hospital setting for the psych under 21 benefit without continuing to require providers obtain JCAHO accreditation. Thus, CMS established the PRTF as a separate type of inpatient setting ("PRTFs," 2013). By removing the JCAHO requirement as originally established in 1972 Federal funding distribution of funds would not be attached to certification.

Brief History of Mental Health

Mental Health has plagued our communities for hundreds of years causing a stigma that is difficult to diminish. Historically people with severe disability were nameless, faceless, and dependent on segregated institutions or a myriad of distinct State government or charity programs , people with disability were poorer and had greater burdens of illness, less private insurance, higher out-of-pocket expenses, and more unmet needs(Master & Taniguchi, 1996). In the United States one in five people are affected by a mental health condition (“NAMI: National Alliance on Mental Illness | NAMI: The National Alliance on Mental Illness,” n.d.). Ten to fifteen percent of the prison population suffers from severe mental illness and seven percent of police contacts with a population of 100,000 or more citizens involve individuals with mental illness (“Center for Problem-Oriented Policing | Problem Guides | People with Mental Illness,” n.d.). 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. In the mid-1950s, psychotropic medication, in particular the antipsychotic medication chlorpromazine, was found that many persons with mental illness could be effectively treated in an outpatient setting("Medicaid Emergency Psychiatric Demonstration," n.d.) Thirty years ago the values of equal rights, independence, and autonomy, which are so prevalent today, had not yet coalesced into a cohesive disability-rights movement because of the pervasive culture of dependency and paternalism, as well as the fragmentation of the various constituencies with disabilities (Master & Taniguchi, 1996). When Medicare was amended in 1973, expanding entitlement to people with disability, it played a key role in promoting independence and autonomy and enhancing health care for this population, which traditionally had been underserved (Master & Taniguchi, 1996). Medicare recipients with disability have been the fastest growing Medicare-entitled population, and Medicare, along with Medicaid, has had to adjust to meet the needs of this ever-changing group. ”(Master & Taniguchi, 1996).

Mental health issues present in many different forms and can range from undiagnosed to severely manic and a public nuisance. The stigma in mental health is attached to those individuals who require treatment but do not have the resources, support, or physical ability to seek the help that is needed for their well being. 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(" Medicaid Emergency Psychiatric Demonstration," n.d.) A Psychiatric Residential Treatment Facilities (PRTF) is a separate, stand alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician. All PRTF residents according to regulation must need inpatient services to treat his or her psychiatric condition under the direction of a physician and the services provided must be reasonably expected to improve the resident’s condition or prevent further regression so that the services will no longer be needed("Psychiatric Residential Treatment Facilities Clarification Ref S&&c-07-15," 2007)

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.

Today, despite limitations, variability, and cost pressures, the State Medicaid programs function as the Nation's only formed disability and LTC insurance program. For people with disabilities, the potential pitfalls of managed care are many, with serious implications for the health of a population that includes some of the most vulnerable members of our societies. According to the new ruling as laid out in 42 C.F.R. §441.151(a)(2)(ii , all Psychiatric Residential Treatment Facilities must be accredited by either Joint Commission, The Commission on Accreditation of Rehabilitation Facilities, The Council on Accreditation of Services for Families and Children, or Any other accrediting organization with comparable standards recognized by the State ("Psychiatric Residential Treatment Facilities Clarification Ref S&&c-07-15," 2007).

The first deinstitutionalization of mental health began in the 1950’s with moving the mentally ill out of state institutions and closing the institutions down (“Deinstitutionalization - Special Reports | The New Asylums | FRONTLINE | PBS,” n.d.). 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. Homelessness is often a problem for the mentally ill due to the deinstitutionalization mental health care. The mentally ill were cast out of the institutions and had no support system in place to assist them with their behavioral health needs. As part of the homeless population the mentally ill often end up as offenders for various reasons and enter into incarceration. Today the prisons and jails house many of the mentally ill that would have received treatment in the days of the asylum. This creates social justice issues and a need for new ways to care for the mentally ill. This history of mental health helps us better understand the developments that led to the state of the current healthcare system. If current behavioral healthcare systems fail to comply with the CMS final rule then an increase in incarcerated mentally ill will occur.

General Hospital Funding

“Hospitals are a basic element of America’s healthcare system. The organization of the hospital system in the United States is unique and complicated. No other country has such a heterogeneous collection of hospitals, payers, or payment methods for hospital services. U.S. hospitals adopt much of the state-of-the-art medical technology, train most new physicians, and are often the point of access to health care for the uninsured” (Laschober & Ventrees, 1995). The American Hospital Association conducts an annual survey of hospitals in the United States (Table 1) and classify them as short-term (acute care) hospitals, teaching hospitals, or long-term care institutions; as public, private nonprofit, or private for profit; or designated by the main type of services provided, such as general, specialty, or referral services.

According to the American Hospital Association the dominant type of hospital in the United States is the community hospital, Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries. “Nonprofit hospitals are operated by organizations such as universities, churches, and other charities, and they are exempt from taxes on surplus revenues. For-profit hospitals are operated by individuals, partnerships, or corporations and pay taxes on their surplus income. Public community hospitals are owned and operated by state or local governments, and they provide care for large numbers of uninsured patients” (Laschober & Ventrees, 1995).

There are hospitals owned and operated by the federal government (serving active military personnel, veterans, and Native Americans), specialty long-term hospitals (e.g., psychiatric, long-term care, rehabilitation), and teaching hospitals that are attached to large academic teaching insinuations. Teaching hospitals, supply primary and tertiary care, provide clinical education, and provides patients and the community with health care for everyday needs and the most specialized services for complex diseases, illnesses and injuries. They Offers unique care not available anywhere else and teaches generations of health care professionals with an eye on training the right mix of providers for tomorrow’s needs. At its foundation is the notion that knowledge comes from questioning the status quo, discovering more about disease and using that knowledge to improve the health of the community, resulting in the development of new technology and carries out research that improves lives.

Financing for hospital services comes from a multitude of private insurers as well as the joint federal-state Medicaid program, the federal, Medicare program. The various third-party insurers pay hospitals through an even wider assortment of methods, including retrospective cost-based reimbursement, discounted charges, and prospective payment based on diagnosis- related groups of cases or based on groups of hospitals with similar costs.

Because Medicare’s payments to hospitals account for a substantial share of their revenues, its payment system and rates have a large impact on hospitals’ financial condition. When Medicare was first established in 1965, mainly to pay for health care for the elderly population, hospitals were reimbursed for inpatient services on the basis of “reasonable cost” plus 2 percent.” “In response to concerns about rising Medicare expenditures, Medicare spending for inpatient hospital services rose between 12 and 20 percent yearly during the early 1980s. A number of constraints were introduced to control Medicare’s hospital outlays these included changing Medicare’s payment method for hospital services away from retrospective payments to a prospective payment schedule with hospital rates set in advance.” (Laschober & Ventrees, 1995). However, because hospital costs for Medicare patients have grown faster than Medicare’s payment updates, hospitals’ Medicare operating margins have steadily declined.

The largest payer of hospital costs remains private insurance, which paid over 35 percent of hospitals’ operating revenues. Hospitals generate additional revenues through investments and private philanthropy and by operating cafeterias, parking lots, and gift shops. These miscellaneous funding sources amounted to 5.1 percent of hospital operating revenues. (Laschober & Ventrees, 1995). Medicaid is the second-largest public payer, targeting low-income families, poor elderly, and the blind and disabled populations. Health Care Financing Administration Medicaid Bureau oversees state administration of individual Medicaid programs. The federal government defines certain guidelines that states must meet to receive federal funding, but states are free to develop their own Medicaid programs within these guidelines.

The University of Chicago Medical Center is large academic hospital established in 1899. Affiliated with and operated by the [University o](https://en.wikipedia.org/wiki/University_of_Chicago)f Chi[cago](https://en.wikipedia.org/wiki/University_of_Chicago), it serves as the [teaching hospital](https://en.wikipedia.org/wiki/Teaching_hospital) for students of the institution's Pritzker School of Medicine, the University of Chicago Biological Sciences Division, and a section committed to scientific discovery. As one of the nation's leading academic medical institutions, it has been at the forefront of medical care since its conception. University of Chicago Medicine physicians are members of the University of Chicago Physicians Group, which includes about 900 physicians and covers the full array of medical and surgical specialties. The physicians are faculty members of the Pritzker School of Medicine.

University of Chicago Medicine consists of:

* Center for Care and Discovery, the primary adult inpatient care facility (opened in 2013 at a cost of $700 million)
* Bernard A. Mitchell Hospital, adult inpatient care facility which houses the Burn and Complex Wound Center
* Comer Children's Hospital, including the University's Pediatric Level 1 Trauma Center
* University of Chicago Medicine Family Birth Center, a maternity and women's hospital
* Duchossois Center for Advanced Medicine, and outpatient care facility
* Pritzker School of Medicine
* The Knapp Center for Biomedical Discovery (KCBD)
* The University of Chicago Comprehensive Cancer Center (in the main campus and other locations)
* regional physician offices located throughout the Chicago area

Methodology

This capstone project used qualitative research methods in order to understand the impact of the CMS Final Rule on Psychiatric Treatment Facilities, Community Mental Health Centers, and Hospitals. In the beginning stages of this project several psychiatric treatment facilities were contacted, via email, phone calls, and in person with little or no response. CMS was contacted, via email, and responded with; “Potential obstacles that a facility may face in implementing the CMS Emergency Preparedness are speculative and would vary by facility. CMS is compiling Frequently Asked Questions that address some of the common issues raised by providers, suppliers, and surveyors. You can find four rounds of these FAQs and additional information regarding this regulation at the link below”. A multifaceted literature review of psychiatric treatment facilities was conducted in order to better understand the impact the ruling would have on the mental health community. The University of Chicago Medical Center (UCMC) was interviewed as a single case study representing a large academic hospital. The interview assessed the hospital’s baseline knowledge and understanding of the final rule and took into account the payer mix ratio and potential roadblocks to implanting the Final Rule requirements in their facility. A literature review of the final rule was conducted and displayed financial trends in mental health.

Participants in this study were contacted via email and provided with a University of Chicago consent form for research participation. The same preliminary emails were sent out to various mental health facilities, treatment centers, and hospitals with few to no responses. The responses from mental health facilities and treatment centers, via email, generally stated they would be unable to help in any research. The responses from mental health facilities and treatment centers, via telephone, forwarded me to various voicemails with no further contact. The University of Chicago Medical Center responded, via email, requesting further correspondence. A telephone interview was set up with an emergency manager overseeing the implementation of the CMS final rule. The interviewees stated they understood by responding, via email, and agreeing to the terms of the consent form for research participation.

Findings / Discussion

**Interview**

On 08/20/2017 an interview with the emergency manager at the University of Chicago Medical Center (UCMC) which is a large academic hospital in the city of Chicago. The University of Chicago Medical Center was selected for this case study for its size, location, and diversity of programs (Table 2). During the interview a variety of topics were discussed as it related to the final rule and the University of Chicago Medical Center.

**How did you become aware of it, how was it delivered presented to your organization?**

The Medical Center became aware of the final ruling by way of a notifications delivered through the Risk management department. UCMC viewed this as less of a burden but more of another project to do. This mindset was a result of Sr. leadership buy in. Sr. leadership does not do EM work on a daily basis but they do have an understanding of the amount of money that could be loss due to not being compliance with the ruling, as a result they have delivered all resources needed to make the new requirements come into fruition.

**How will this ruling affect your facility as it currently operates?**

Large hospitals such as UCMC has a mutual agreement between CMS and JCAH called Deeming Compliance (deemed compliance). Under this compliance CMS recognizes Joint Commission accreditation for purposes of Medicare participation for various kinds of health care organizations. “To participate in the Medicare program, providers and suppliers of health care services, must be substantially in compliance with specified statutory requirements of the Social Security Act (the Act), as well as any additional regulatory requirements specified by the Secretary of the Department of Health and Human Services (HHS). These requirements are generally called “conditions of participation” (CoPs) for most providers, “requirements” for skilled nursing facilities (SNFs), “conditions for coverage” (CfCs) for ambulatory surgical centers (ASCs) and other suppliers, and “conditions for certification” for rural health clinics (RHCs). A provider or supplier that does not substantially comply with the applicable requirements risks having its participation in the Medicare program terminated. In accordance with section 1864 of the Act, state health departments or similar agencies, under an agreement with CMS, survey institutional health care providers and suppliers to ascertain compliance with the applicable CoPs, CfCs, conditions of certification, or requirements (as applicable), and certify their findings to us. Based on these state survey agency (SA) certifications, we determine whether the provider or supplier qualifies, or continues to qualify, for participation in the Medicare program” ("Medicare and Medicaid Programs: Revisions to Deeming Authority Survey, Certification, and Enforcement Procedures," 2015). Under the deemed authority the UCMC is currently in compliance with all CMS requirements because they are currently in good standing with JCAH. Good standing is defined as passing a Joint commission accreditation inspection.

**What would be the current burden placed on your facility to meet the criteria of the final rule?**

In the grand scheme of the ruling it’s a big deal with large academic healthcare systems such as University of Chicago Medical Center because of the population that the systems services. Despite revenue from other sources (research, federal grants, alumni donations, and private non-academic donations) it’s not enough to cover the gap that would be created by the loss of Medicare funds because UCMC has a significant Medicare payer ratio. The new ruling does not provide new money but still require institutions to still meet the requirements the financial burden of the ruling lay in program development and implementation.

**Was there an emergency management plan in place prior to the rule and was it certified locally by emergency managers?**

The UCMC already has an all hazards program that has been written, tested, revised, and evaluated by a number of professional authorities. UCMC has to insert the new CMS requirements into their existing system. Whereas smaller facilities such as mental health facilities will suffer more because they lack the resources and systems needed to implement the ruling. To give you more clarification prior to the ruling our facility had the following in place:

1. Communication plan which was made up of:
   1. Email
   2. Text page system
   3. Personal mobile text message system
   4. Internal overhead communication system
2. Entire education and training department which provides
   1. Mandatory training program and instructor for staff.
   2. Dedicated systems to allow for staff to train during working hour
   3. Dedicated funds to use for staff required training payed in the form of education overtime.
   4. Money needed to pay for staff training outside of normal working hours
   5. Annual disaster drills
3. Manpower
   1. People to write and develop
   2. People to train and evaluate
   3. People to sustain program (HR, IT, Educators)
4. Physical resources
   1. Mass communication equipment and software
   2. Newly developed emergency and disaster safety equipment
   3. Training equipment
   4. computers

**Is your facility able to meet the time constraints of the final rule?**

UCMC is on track with CMS requirements and will need to insert the new CMS requirements into their existing emergency preparedness program. UCMC will meet the November 2017 deadline for CMS requirements to include training staff. UCMC EM’s acknowledged senior leadership as the primary reason the CMS requirements are viewed as a project to complete than a burden to the medical center. Senior leadership has bought into the emergency management program, provides EM’s with the necessary resources, and recognizes compliance is necessary in order to avoid financial complications in the future

**Do you foresee any roadblocks to implementing requirements of the new emergency management plan that’s laid out in the ruling?**

The Medical Center does not see any major roadblocks in implementation because of our existing systems we have in place. The Medical Center does not have to create or develop a new emergency management program and will be on track with compliance. We are just adding new language to their existing system. We will meet the required deadline including new training for all staff, by the end of fiscal year.

Another advantage we have in the current organizational structure. UCMC has three full time emergency managers working on a variety of emergency management aspects. The three EM’s does not include the risk management, compliance and regulatory departments who they work with sided by side on a daily basis to ensure the medical center is meeting and exceeded any requirements, this type of system and does not exists in smaller facilities such as mental health centers.

**The final rule places a higher expectation on the abilities of employee who work for your facility. Will there be any issues with training your existing employees on the emergency management?**

Large hospitals have more resources to put into an emergency management program development. UCMS has developed:

**Waterfall compliance** – Current employees got new emergency management training in the form of a new computer based training.

**New employee onboarding** – New employees have the emergency management training included in their employee orientation program and are evaluated on their companies 90 days after.

**Annual training**- New requirements are implemented in all staff annual requirements.

In the grand scheme of the ruling it’s a big deal with large academic healthcare systems such as University of Chicago Medical Center because of the population that the systems services.

In our original proposal we stated that we would also perform a multifaceted case study on a smaller behavioral health facility. The case study on a smaller behavioral health facility was unable to be completed due to a lack of cooperation. Several facilities were contacted via email, over the phone, and in person. When the smaller facilities were contacted they all provided the same or similar response that they could not provide us with the information we were looking for. A couple facilities acknowledge that they are preparing for the implementation of the CMS final rule requirements while others were unaware of the new requirements. In order to provide a complete understanding of potential impact of the final rule could have on behavioral health facility we conducted a historical based case study focused on adverse results of mental healthcare cuts. The correlation mimics potential cuts that would result from non-compliance with the final rule. This investigation gave us space to establish a sound platform from which to explore the factors in greater detail. The most significant benefit of case studies is that it enable a holistic review of the topic material while enabling us to gain a more detailed, un-biased understanding of a complex situation, through the use of a range of research tools. This real-life view, places the research in a stronger position to confidently recommend practical solutions to challenges.

Case Studies: Adverse results of Mental Health Care cuts

Historically when there are cuts to be made in healthcare, mental healthcare stands to be the first to be eliminated. In 2011, the National Alliance on Mental Illness published the report *State Mental Health Cuts: A National Crisis.* This report documents the state-by-state funding changes for public mental health services since 2009 for youth and adults living with serious mental illness. According to the report “states have cut vital services for tens of thousands of youth and adults living with the most serious mental illness. These services include community and hospital based psychiatric care, housing, and access to medications” (State Mental Health Cuts: A National Crisis 2011). The Mental Health System is already a crumbling system, with the addition of this ruling it only exacerbates the system. Even during the best of economic times, youth and adults living with mental illness struggle to access essential mental health services and supports. Services are often unavailable or inaccessible for those who need them the most. About five million American children suffer mental illnesses ranging from schizophrenia, bipolar disorder, major depression, and other conditions that are severe enough to cause significant life impairment making them unable to live safely at home or attend and benefit from school. There is little coordination of care and various agencies in health, education, mental health, addiction, disability, child welfare and law enforcement, often work at cross-purposes. The debate has thrown a harsh light on the piecemeal nature of America’s mental health system, which is leaving too many children and young adults, without the resources they need. *Time Magazine* contributor Maia Szalavitz has done extensive research into the failing American mental health care system. Szalavitz has found in her research that services for mental health issues are often offered based on the diagnosis, how doctors or other health officials label children’s disorders, and how they prioritize those that occur in concert, can have an indelible impact on whether child finds the appropriate treatment in the health, education, child welfare, or legal systems. Additionally funding has also dramatically declining: according to data from the Department HHS states have lost some $4 billion in mental health funding over the past three years, the largest cuts since the de-institutionalization movement of the 1970s, and those cuts could get deeper.

Communities pay a high price for cuts of this magnitude. Unfortunately, the public often focuses on mental illness and the tremendous impact it can have on the community when high visibility tragedies of the magnitude of events, like the Tucson 2011 shooting or the 2007 Virginia Tech shooting , Loughner the shooter in Tucson who’s actions resulted in 18 injured and 6 dead, was found by a federal judge to be [incompetent to stand trial](https://en.wikipedia.org/wiki/Competence_(law)) based on two [medical evaluations](https://en.wikipedia.org/wiki/Competency_evaluation_(law)). Since the Virginia Tech where student Seung-Hui Cho gunned down 27 fellow students and 5 faculty members and injured 24 other people before taking his own life, some disturbing facts about his mental health history have emerged. At various points during Cho's college career, Virginia Tech police officers, professors, and students recognized that he was mentally troubled. Unfortunately, there was no clear way to screen Cho for reentry to Virginia Tech in the fall of 2005. The school's counseling center did not accept “involuntary or ordered referrals for treatment from any source,” according to the inspector general's report, and even students with “thought disorders” were treated only if they were willing to be served. In addition, according to an article in the student newspaper that fall, the university was facing a crisis at its counseling center, whose only psychiatrist had left and hadn't been replaced. “There is a profound shortage of psychiatrists in the college's very poverty-stricken, rural, rugged area, “explains psychiatrist Joe Frieben, who worked part-time at Virginia Tech this past year. The college newspaper reported that students requiring prescriptions for controlled medications might need to travel to Roanoke, 45 minutes away (Shuchman, 2007)

Less than one year later, the Virginia legislature improved the emergency evaluation process, modified the criteria for involuntary commitment, tightened procedures for mandatory outpatient treatment, and increased state funding for community mental health services. The unanswered question, however, is whether the necessary political momentum can be sustained for the long-term investment in community services and the fundamental legal changes needed to transform a system focused on managing access to scarce hospital beds to a community-based system of accessible voluntary services. (Bonnie, Reinhard, Hamilton, & Mcgarvey, 2009). “However, less visible tragedies take place every day in our communities, suicides, homelessness, arrests, incarceration, school dropout and more. These personal tragedies also occur because of our failure to provide access to effective mental health services and supports” (Honberg, Diehl, Kimball, Gruttadaro, & Fitzpatrick, 2011).

Emergency rooms are becoming the primary treatment centers for homeless population who are often affected by mental health illness. Addressing the health needs of the homeless population is a challenge to physicians, health institutions, and federal, state, and local governments. Homelessness is pervasive in the United States, and an estimated 3.5 million individuals are likely to experience homelessness in each year. Homeless adults are frequent users of costly emergency department and hospital services, largely paid for by public dollars. The combination of chronic medical illnesses and poor access to primary health care has substantial health and economic consequences. The mental health system and the police have a long history of interaction. A study examining crisis response services in 69 U.S. communities noted that law enforcement officers play a critical role in mobile crisis services, particularly in aiding in potentially dangerous situations. Despite these findings, a survey of California law enforcement agencies suggested most law enforcement officers are given insufficient training in identifying, managing, and referring mentally ill persons. (Deane, Steadman, Veysey, & Morrissey, 1999).

The creators of the policy change did not fully understand the reality of implantation. Some commenters stated the proposed requirements are inappropriate because they mostly apply to hospitals, and cannot be applied to other healthcare settings. A commenter noted smaller hospitals with limited capabilities, like long term care facilities should be allowed to work with their local emergency response networks to develop emergency preparedness plans reflect those hospitals’ limitations.

The original purpose of this capstone project was to identify the potential obstacles the 17 different supplier and provider types would face in implementing the CMS final rule on emergency preparedness with a focus on a large academic medical hospital and a smaller mental health facility. This project was meant to provided needed awareness on a fluid and constantly developing topic of emergency preparedness according to the CMS final rule. We believe we were able to identify the pitfalls of non-compliance with the final rule and the need for facilities to build relationships within the community to create awareness and advocacy for the mental health care system. Community partners, business partners, and other stakeholders should take notice of the final rule and ensure their community behavioral health centers are in compliance. Compliance benefits the whole community, protects vulnerable populations, and ensures the medical community is available to provide much needed services.

The biggest limitation to this study was the lack of new information available on the implementation of the CMS final rule. Over the past year there have been many videos posted online of meeting hosted by CMS and other entities that provided a step by step guide on how to implement the CMS final rule requirements. This information was helpful in understanding the expectation of the final rule and how these requirements may impact the medical community in both a positive and negative way. The long term goal of the rule is to improve the means by which employees are trained and react to various types of disaster. Other limitations were a lack of cooperation from smaller facilities to provide detailed information about their facility. This information would have allowed us to compare and contrast the ability of smaller facilities and large academic hospitals to be in compliance with the final rule. It can be extrapolated that with the information available to smaller facilities on the CMS website that they would be able to meet the requirements of the CMS final rule. The financial picture of these facilities cannot be estimated due to the various types of facilities and the services they provide our communities.

If we were to design this capstone again we would focus on the policy of the CMS final rule and how local communities could have been made aware of the negative social impacts non-compliance with the final rule could have.

Recommendations

Our recommendation for future research includes data collection from the 17 supplier and provider types over the next year. The goal would be to have several of the 17 different supplier and provider types participate in the data collection process with anonymity. The data collection would include the dates of facility compliance, dates of non-compliance, how long each facility has not been in compliance, and the steps the facility took to achieve compliance. Data from the financial issues non-compliance caused and the steps each facility took in developing partners and stakeholders to increase the financial fortitude of each facility. Additional information about the roadblocks or pitfalls each facility experienced in implementing the final rule would provide valuable insight in future changes or mandates. Ultimately this information would assist in streamlining the process of implementation and reduce the cost to facilities when implementing these new mandates.

Table and Figures

**Table 1 : Fast Facts on US Hospitals**

|  |  |
| --- | --- |
| Total Number of All U.S. [Registered](http://www.aha.org/aha/resource-center/Statistics-and-Studies/REGISTRATION_FY_08.pdf#registered) Hospitals | 5,564 |
| Number of U.S. [Community](http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html#community) Hospitals | 4,862 |
| Number of Nongovernment Not-for-Profit Community Hospitals | 2,845 |
| Number of Investor-Owned (For-Profit) Community Hospitals | 1,034 |
| Number of State and Local Government Community Hospitals | 983 |
| Number of Federal Government Hospitals | 212 |
| Number of Nonfederal Psychiatric Hospitals | 401 |
| Number of Nonfederal Long Term Care Hospitals | 79 |
| Number of Hospital Units of Institutions  (Prison Hospitals, College Infirmaries, Etc.) | 10 |
| Total Staffed Beds in All U.S. [Registered](http://www.aha.org/aha/resource-center/Statistics-and-Studies/REGISTRATION_FY_08.pdf) Hospitals | 897,961 |
| Staffed Beds in Community Hospitals | 782,188 |
| Total Admissions in All U.S. [Registered](http://www.aha.org/aha/resource-center/Statistics-and-Studies/REGISTRATION_FY_08.pdf) Hospitals | 35,061,292 |
| Admissions in Community Hospitals | 33,260,348 |
| Total Expenses for All U.S. [Registered](http://www.aha.org/aha/resource-center/Statistics-and-Studies/REGISTRATION_FY_08.pdf) Hospitals | $936,531,524,400 |
| Expenses for Community Hospitals | $851,514,523,144 |
| Number of Rural Community Hospitals | 1,829 |
| Number of Urban Community Hospitals | 3,033 |
| Number of Community Hospitals in a [System](http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html#system) | 3,198 |
| Number of Community Hospitals in a [Network](http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html#network) | 1,677 |

Source: Fast Facts on US Hospitals (2017 by Health Forum LLC, an affiliate of the American Hospital Association)

**Table 2 : University of Chicago Medicine Fast Facts: As of June 30, 2016, unless otherwise noted**

|  |  |
| --- | --- |
| Licensed Beds | 811 |
| Employees  (includes Medical Center and Biological Sciences Division) | 9,000 |
| Attending Physicians | 842 |
| Nurses  (includes RNs and LPNs from Medical Center and Biological Sciences Division) | 2,446 |
| Residents & Fellows | 1,129 |
| Outpatient Encounters  (includes clinic visits, procedures/surgeries, emergency room, and observation stays in acute care areas) | 760,201\* |
| Hospital Patient Days | 188,494\* |
| Emergency Room Visits  (59,295 adult and 31,441 pediatric)\* | 90,736 |
| Hospital Admissions | 29,809\* |
| Surgeries | 20,437\* |
| Births | 2,069\* |
| Operating Revenue | $1.6 billion\* |
| Community Benefits and Services  (includes Medicaid and Medicare losses, charity care, unrecoverable patient debt, medical education and research, contributions/donations and uncategorized benefits from data prepared for the state and IRS for fiscal 2015) | $312 million\*  (FY2015) |
| Uncompensated Care  (Includes Medicare and Medicaid program losses, charity care, unrecoverable patient debt) | $195.8 million\*  (FY2015) |
| Affiliated Nobel Prize Winners | 12 |
| NIH Funding | $128.6 million |

Source : University of Chicago Medical Center

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