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BEHAVIORAL HEALTH UPDATE: August 2015  
A Monthly Report for Members  
of the American Hospital Association [www.aha.org](http://www.aha.org) and the  
National Association of Psychiatric Health Systems, [www.naphs.org](http://www.naphs.org)

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1. AHA and NAPHS comment on Medicaid/CHIP managed care proposed rule.
2. **Senate committee approves emergency psychiatric care bill.**
3. HHS creates demonstration and announces funding to expand addiction treatment.
4. Hospital OPPS proposed rule includes CY16 partial hospital rates and planned changes to two-midnight policy.
5. Reminder: IPF quality reporting data-submission period runs through August 15.
6. Hold August 20 and September 17 for next IPFQR webinars.
7. Need for psychiatric inpatient services continues to grow, NAPHS annual survey finds.
8. **CDC reports on trends, risk factors behind heroin epidemic.**
9. Nearly one-third of community hospital stays involve at least one mental health or substance use disorder, AHRQ reports.
10. AHRQ finds mental health and substance use disorders among the top 10 principal diagnoses for “super-utilizers” in community hospitals.
11. HHS offers training resources for the healthcare workforce on multiple chronic conditions.
12. GAO reports on options for low-income adults to receive behavioral health services in selected states.
13. Longitudinal study suggests adult success linked to childhood psychiatric health.
14. AHRQ reports on youths’ behavioral medication use.
15. Study: Boys more likely to have antipsychotics prescribed, regardless of age.
16. **Report examines disparities in behavioral health, treatment.**
17. CDC looks at racial and ethnic disparities in men’s use of mental health treatments.
18. Report presents framework to establish standards for psychosocial interventions for mental health and substance use disorders.
19. Exchange plans include fewer providers than the average for commercial plans, report finds.
20. Plan now for “Recovery Month” in September.

**1. AHA AND NAPHS COMMENT ON MEDICAID/CHIP MANAGED CARE PROPOSED**

**RULE.** In a [proposed rule](#) that updates – for the first time in more than a decade – regulations governing managed Medicaid, the Centers for Medicare and Medicaid Services (CMS) recommended a change that would allow payment to Institutions for Mental Disease (IMD) for adults (ages 21-64) receiving behavioral health services in freestanding psychiatric hospitals and in subacute IMDs offering “crisis residential” services. In separate comment letters, both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) told CMS that they were supportive of expanding access to IMDs. Both associations also urged CMS to expand the definition of short-term stays beyond the agency’s proposed limit of 15 days in an IMD. In the [AHA comment letter](#), AHA Executive Vice President Rick Pollack noted that CMS data showing that 7.1% of adults currently met the criteria for a serious mental illness and 13.6% of uninsured adults within the Medicaid expansion population have a substance use disorder. “These data underscore the need to improve access to short-term inpatient psychiatric and substance abuse disorder treatment,” he wrote. In the [NAPHS comment letter](#), NAPHS President/CEO Mark Covall said that NAPHS believes that “the CMS proposal represents a major step forward in the care and treatment of those with mental illness and substance use disorder.”

**2. SENATE COMMITTEE APPROVES EMERGENCY PSYCHIATRIC CARE BILL.** The Senate Finance Committee recently approved a bipartisan bill backed by both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) to support access to emergency psychiatric care for underserved and vulnerable populations. S. 599 would extend the Medicaid Emergency Psychiatric Demonstration Program through September 2016 or whenever the Department of Health and Human Services completes its final evaluation of the project, whichever occurs first, as long as the extension would not increase Medicaid costs. It also would allow HHS to extend the demonstration project, set to expire this year, for an additional three years and to other states, subject to the same budget-neutrality standard. The bill now awaits consideration by the full Senate and the House of Representatives.

**3. HHS CREATES DEMONSTRATION AND ANNOUNCES FUNDING TO EXPAND ADDICTION TREATMENT.** The Department of Health and Human Services (HHS) has announced a major initiative to combat opioid abuse and expand treatment and services for substance abuse. As part of this initiative, the Centers for Medicare and Medicaid Services (CMS) has issued [guidance](#) to state Medicaid directors (SMD #15-003) outlining a new opportunity for Medicaid section 1115 demonstration projects to test Medicaid coverage of a full substance use disorder (SUD) treatment service array in the context of overall SUD service delivery system transformation, provided participating states meet specific requirements. Through this initiative, states may receive federal financial participation (FFP) for costs not otherwise matchable, such as services delivered to targeted populations, in limited geographic areas, or in settings, such as Institutions for Mental Diseases (IMDs), that are not otherwise covered under the Medicaid program. In a [press release](#), HHS also announced more than \$100 million in funding for states and community health centers to help combat opioid abuse and expand treatment and services for substance abuse. The Health Resources and Services Administration (HRSA) will make \$100 million available in additional funding to improve and expand the delivery of substance use disorder services, with a focus on medication-assisted treatment for opioid use disorder. The Substance Abuse and Mental Health Services Administration (SAMHSA) is [awarding](#) up to \$11 million annually to 11 states (IA, IN, KY, MA, MD, MO, NJ, VT, WA, WI, WY) to increase access to comprehensive medication-assisted treatment for opioid use disorders (for a total of up to \$33 million over the next three years).

**4. HOSPITAL OPPTS PROPOSED RULE INCLUDES CY16 PARTIAL HOSPITAL RATES AND PLANNED CHANGES TO TWO-MIDNIGHT POLICY.** The Centers for Medicare & Medicaid Services (CMS) published a [proposed rule](#) in the July 8 *Federal Register* on the hospital outpatient prospective payment system (OPPS), which includes partial hospital rates that would be applicable to services furnished on or after January 1, 2016. In the proposed rule, CMS proposes to use new APC numbers for the Medicare APCs in 2016 for both hospital-based and community mental health center (CMHC) partial hospitalization programs as part of their overall restructuring and renumbering of the OPPTS APCs. The proposed rates for CY16 are as follows: 1) hospital-based PHP with 3 services (Level 1) = \$185.27 (an increase of 3.4% over CY15); 2) hospital-based PHP with 4 or more services (Level 2) = \$207.24 (a 5.9% increase); 3) CMHC PHP with 3 services (Level 1) = \$100.17 (a 3.79% increase); and 4) CMHC PHP with 4 or more services (Level 2) = \$139.62 (a 22.2% increase). In the proposed rule, CMS says that the “two-midnight” rule (regarding when inpatient admissions are appropriate for payment under Medicare Part A) will stay in effect, but proposes to allow physicians to make the judgment when admitting patients for short hospital stays. Quality Improvement Organizations (rather than CMS contractors) would enforce the policy. According to a [CMS two-midnight fact sheet](#), “QIOs will oversee the majority of patient status audits, with the Recovery Audit program focusing on only those hospitals with consistently high denial rates.” A [CMS summary news release](#) is online. AHA and NAPHS will be analyzing the rule in detail and providing comments to CMS, which are due August 31.

**5. REMINDER: IPF QUALITY REPORTING DATA-SUBMISSION PERIOD RUNS THROUGH AUGUST 15.** The *QualityNet Secure Portal* and Web-based Measures Application are now available for you to submit the next round of Inpatient Psychiatric Facility Quality Reporting (IPFQR) data. The data submission period is open until August 15, 2015, to report measure data, complete the Data Accuracy and Completeness Acknowledgement (DACA), and file the Notice of Participation (NOP) for FY2016. See a [briefing](#) on “Tips to Avoid Errors During Submission of Web-based Measure Data for FY2016.” Also review the recent (July 15) IPFQR webinar titled “**Keys to Successful FY 2016 Reporting**,” which can be downloaded from [www.QualityReportingCenter.com](http://www.QualityReportingCenter.com) at <http://www.qualityreportingcenter.com/inpatient/ipf/events/>.

**6. HOLD AUGUST 20 AND SEPTEMBER 17 FOR NEXT IPFQR WEBINARS.** Mark your calendars now for the next two educational webinars scheduled for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. An August 20 webinar will focus on the “SUB-1 Measure.” A September 17 webinar will examine the “FY2016 IPF PPS Final Rule.” Notices will be sent to those signed up for the IPFQR listserv and posted at [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com).

**7. NEED FOR PSYCHIATRIC INPATIENT SERVICES CONTINUES TO GROW, NAPHS ANNUAL SURVEY FINDS.** The need for psychiatric services in inpatient hospitals continues to grow, according to the latest annual survey from the National Association of Psychiatric Health Systems (NAPHS). The survey reports 2013 data that was collected in 2014 from NAPHS-member organizations. Data were analyzed and reported by Dobson DaVanzo & Associates, LLC, Vienna, VA. Trended admissions and days of care in inpatient hospitals have increased over the past year (while inpatient length of stay has remained constant), the survey reports. To accommodate for increased utilization in inpatient facilities, both occupancy and bed size increased from 2012 to 2013. Inpatient occupancy increased 0.3%, while the number of set-up and staffed beds in inpatient facilities increased 5.2% from 2012 to 2013. “While trended inpatient days of care increased by 6.5% since 2012, outpatient services also showed growth with the average number of outpatient visits in 2013 increasing by 4.4% since the prior year,” noted NAPHS President/CEO Mark Covall in the report. Conversely, the average number of partial hospitalization visits decreased 5.1% from 2012 to 2013. Trended utilization days of psychiatric services in residential treatment centers also decreased (a decrease of 4.6%) from 2012 to 2013, with members reporting a lower number of admissions (a decrease of 16.0% from 2012) but a longer average length of stay (an increase of 3.9% from 2012). The report is available to the public for \$400. Online [ordering information](#) and a [Table of Contents](#) are at [www.naphs.org](http://www.naphs.org).

**8. CDC REPORTS ON TRENDS, RISK FACTORS BEHIND HEROIN EPIDEMIC.** Heroin use increased 63% among U.S. residents between 2002 and 2013, while the death rate from heroin-related overdoses nearly quadrupled, according to a [report](#) from the Centers for Disease Control and Prevention (CDC). Abuse or dependence on opioid pain relievers “was the strongest risk factor for heroin abuse or dependence,” the report adds, noting that most heroin users have a history of nonmedical use of prescription opioid pain relievers. “Heroin use is increasing at an alarming rate in many parts of society, driven by both the prescription opioid epidemic and cheaper, more available heroin,” [said](#) CDC Director Tom Frieden, M.D. “To reverse this trend we need an all-of-society response – to improve opioid prescribing practices to prevent addiction, expand access to effective treatment for those who are addicted, increase use of naloxone to reverse overdoses, and work with law enforcement partners like DEA to reduce the supply of heroin.” Infographics and additional information are [online](#).

**9. NEARLY ONE-THIRD OF ADULTS’ COMMUNITY HOSPITAL STAYS INVOLVE AT LEAST ONE MENTAL HEALTH OR SUBSTANCE USE DISORDER, AHRQ REPORTS.** In 2012, nearly one in three (32.3%) of adults’ inpatient stays in general hospitals (or a total of 8.6 million inpatient stays) involved at least one mental disorder (MD) or substance use disorder (SUD), according

to a statistical brief (#191) from the Agency for Healthcare Research and Quality (AHRQ). Nearly 1.6 million inpatient stays (or 6.7% of all adults' stays in general hospitals) were *primarily* for mental health and substance use disorders, according to [Hospitalizations Involving Mental and Substance Use Disorders Among Adults, 2012](#). The brief notes that among stays with a primary MD/SUD diagnosis, 13.9% lacked insurance, a number that was more than two times greater than among stays without MD/SUD diagnoses (6.0%). Medicare and Medicaid covered 56% of all inpatient stays with a primary MD or SUD, including those with co-occurring MD/SUDs. The analysis is part of AHRQ's Healthcare Cost and Utilization Project (HCUP), which is based on data from short-term, non-federal general hospitals (other than neonatal and maternal stays). Psychiatric and substance use hospitals are also excluded from the database.

**10. AHRQ FINDS MENTAL HEALTH AND SUBSTANCE USE DISORDERS AMONG THE TOP 10 PRINCIPAL DIAGNOSES FOR “SUPER-UTILIZERS” IN COMMUNITY HOSPITALS.** Mental health and substance use disorders were among the top 10 principal diagnoses for “super-utilizers” aged 1 to 64 years – regardless of payer, according to a recent Agency for Healthcare Quality and Research (AHRQ) Statistical Brief (#190). The report, titled [Characteristics of Hospital Stays for Super-utilizers by Payer, 2012](#), defines super-utilizers “as privately insured patients with three or more hospital stays in 2012 or patients covered by Medicare or Medicaid with four or more stays in 2012.” Mental health stays also were more common for super-utilizers than for other patients among privately insured (7.7% vs. 5.7%) and Medicaid patients (19.3% vs. 11.6%). Among Medicaid patients younger than 65 in 2012, mood disorder was the most common diagnosis for super-utilizers with four or more hospital stays. The report is based on data from the Healthcare Cost and Utilization Project (HCUP), which is based on data from short-term, non-federal general hospitals.

**11. HHS OFFERS TRAINING RESOURCES FOR THE HEALTHCARE WORKFORCE ON MULTIPLE CHRONIC CONDITIONS.** New training material to help healthcare professionals gain the education necessary to care for people living with multiple chronic conditions has been launched by the Department of Health and Human Services (HHS). HHS defines chronic conditions as both physical conditions (such as arthritis, cancer, and HIV infection) and mental/cognitive disorders (such as depression, substance addiction, and dementia). The HHS [Education and Training Resources on Multiple Chronic Conditions \(MCC\) for the Healthcare Workforce](#) materials – a first of their kind – were created by the Office of the Assistant Secretary for Health, in collaboration with the Health Resources and Services Administration (HRSA). The resources are available [online](#) and include: 1) a searchable database of existing educational resources that specifically address the care of persons living with MCC; 2) a conceptual model that outlines the core domains and competencies for the interprofessional healthcare team and; 3) a web-based course consisting of six modules. Read more about the [HHS Initiative on Multiple Chronic Conditions](#) online.

**12. GAO REPORTS ON OPTIONS FOR LOW-INCOME ADULTS TO RECEIVE BEHAVIORAL HEALTH SERVICES IN SELECTED STATES.** Of the 3 million low-income, uninsured adults estimated to have a behavioral health condition, the Government Accountability Office (GAO) reports that “nearly half—approximately 1.4 million people, or about 49%—lived in the 22 states that had not expanded Medicaid as of February 2015, compared with the approximately 1.5 million people in the remaining 29 states that had expanded Medicaid.” The estimated prevalence of behavioral health conditions overall among low-income, uninsured adults was about 17%, on average, in both expansion and non-expansion states, according to a GAO letter report titled “[Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States](#)” (GAO-15-449). Among other data, the report includes state-by-state estimates of the number and percentage of low-income, uninsured adults with a serious mental illness, a substance use condition, or both conditions.

**13. LONGITUDINAL STUDY SUGGESTS ADULT SUCCESS LINKED TO CHILDHOOD PSYCHIATRIC HEALTH.** Children with even mild or passing bouts of depression, anxiety, and/or behavioral issues were more inclined to have serious problems that complicated their ability to lead successful lives as adults, according to research published online July 15 in *JAMA Psychiatry*. In [Adult Functional Outcomes of Common Childhood Psychiatric Problems: A Prospective, Longitudinal Study](#), researchers reported that children who had either a diagnosed psychiatric condition or a milder form that didn't meet the full diagnostic criteria were six times more likely than those who had no psychiatric issues to have difficulties in adulthood, including criminal charges, addictions, early pregnancies, education failures, residential instability and problems getting or keeping a job. The report is based on data from the Great Smoky Mountains Study, which began nearly two decades ago and includes 1,420 participants from 11 North Carolina counties. "If the goal of public health efforts is to increase opportunity and optimal outcomes, and to reduce distress," said the researchers, "then there may be no better target than the reduction of childhood psychiatric distress—at the clinical and subthreshold levels."

**14. AHRQ REPORTS ON YOUTHS' BEHAVIORAL MEDICATION USE.** In 2012, 4.2% of children and teenagers ages 5 to 18 took one or more behavioral medications (or 2.42 million of 58.35 million children and teenagers), according to an Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Statistical Brief (#473). The percentage of boys in this age group taking one or more behavioral medications was more than double the percentage of girls (6.0% vs. 2.3%) in 2012. Youth with public-only insurance and those with any private insurance were more likely to take one or more behavioral medications (4.9% and 4.0%, respectively) compared with uninsured children and teenagers (1%) in 2012. See [Behavioral Medication Utilization in Children and Teenagers Ages 5-18 in the U.S. Civilian Noninstitutionalized Population, 2012](#).

**15. STUDY: BOYS MORE LIKELY TO HAVE ANTIPSYCHOTICS PRESCRIBED, REGARDLESS OF AGE.** Boys are more likely than girls to receive a prescription for antipsychotic medication regardless of age, according to a study ("[Treatment of Young People with Antipsychotic Medications in the United States](#)") published online July 1 in *JAMA Psychiatry*. Approximately 1.5% of boys ages 10-18 received an antipsychotic prescription in 2010, although the percentage falls by nearly half after age 19. Among antipsychotic users with mental disorder diagnoses, attention deficit hyperactivity disorder (ADHD) was the most common among youth ages 1-18, while depression was the most common diagnosis among young adults ages 19-24 receiving antipsychotics. A National Institute of Mental Health (NIMH) [analysis](#) of the study notes that "the U.S. Food and Drug Administration (FDA) has approved antipsychotics for children with certain disorders, particularly bipolar disorder, psychosis/schizophrenia, and autism. However, the research team found that the medication use patterns do not match the illness patterns. The mismatch means that many antipsychotic prescriptions for young people may be for off-label purposes, that is, for uses not approved by FDA," NIMH said.

**16. REPORT EXAMINES DISPARITIES IN BEHAVIORAL HEALTH, TREATMENT.** A [Behavioral Health Equity Barometer](#) report from the Substance Abuse and Mental Health Services Administration (SAMHSA) provides a one-year snapshot of the state of behavioral health of youth and adults by demographics and insurance status based on data from the National Survey on Drug Use and Health. Adults without health insurance were significantly more likely to have experienced a serious mental illness in the past year than adults who had health insurance (5.9% vs. 3.9%), according to the report. Among adults experiencing a serious mental illness, those who were not insured were less likely to receive mental health treatment/counseling in the past year (50.6%) than adults that had health insurance (73.5%). White adolescents were more likely to smoke cigarettes and binge on alcohol than those in other racial and ethnic groups, and female adolescents were three times more likely than males to report a major depressive episode in the past year, the report indicates. While illicit drug use

declined among white and Hispanic adolescents in 2013, it was unchanged among African Americans. “These findings should heighten our awareness of these challenges and provide crucial insight as to how we must all work together to provide the highest quality behavioral healthcare services for all segments of our community.” said SAMHSA Administrator Pamela S. Hyde.

**17. CDC LOOKS AT RACIAL AND ETHNIC DISPARITIES IN MEN’S USE OF MENTAL HEALTH TREATMENTS.** Some 8.5% of men had daily feelings of anxiety or depression, according to a data brief (#206) prepared by the Centers for Disease Control and Prevention’s (CDC’s) National Center for Health Statistics (NCHS), but the rate differed by race and ethnicity. About 4 in 10 men with daily feelings of anxiety or depression took medication for these feelings or talked to a mental health professional, but the rate also differed by race and ethnicity. The significant racial and ethnic disparity in treatment utilization was associated with lack of health insurance coverage, the report finds. “Recent expansions of health insurance coverage may consequently reduce these racial and ethnic disparities,” the authors of [Racial and Ethnic Disparities in Men’s Use of Mental Health Treatments](#) suggest.

**18. REPORT PRESENTS FRAMEWORK TO ESTABLISH STANDARDS FOR PSYCHOSOCIAL INTERVENTIONS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS.** “A considerable gap exists in mental health and substance abuse treatments known as psychosocial interventions between what is known to be effective and those interventions that are commonly delivered,” [says](#) the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine) in a new report. [Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards](#) summarizes the work of an expert committee charged with proposing a framework that can be used to establish standards for psychosocial interventions (such as psychotherapies, community-based treatments, vocational rehabilitation, peer support services, and integrated care interventions). The committee recommended that “psychosocial interventions be elevated to equal regard as physical health care, measurement and improvement strategies used in mental health care be equated with those used in physical health care, and greater emphasis be given to context and infrastructure for high-quality psychosocial interventions.” The committee also called on the Department of Health and Human Services (HHS) to adopt the committee’s framework to support policy, research, and implementation strategies designed to promote the use of evidence-based psychosocial interventions.

**19. EXCHANGE PLANS INCLUDE FEWER PROVIDERS THAN THE AVERAGE FOR COMMERCIAL PLANS, REPORT FINDS.** The average *Affordable Care Act* (ACA) exchange plan has 34% fewer providers than the average plan offered in individual and group markets outside the exchanges, according to an Avalere Health [analysis](#). The analysis found 32% fewer mental health and primary care providers in exchange plan networks, as well as 24% fewer hospitals. The report looked at the largest rating regions in California, Florida, Georgia, Texas and North Carolina.

**20. PLAN NOW FOR “RECOVERY MONTH” IN SEPTEMBER.** The month of September has been designated by the Substance Abuse and Mental Health Services Administration (SAMHSA) as Recovery Month “to increase awareness and understanding of mental and substance use issues and celebrate the people who recover.” The theme is “Join the Voices for Recovery: Visible, Vocal, Valuable.” See [www.recoverymonth.gov](http://www.recoverymonth.gov) for resources, including a [toolkit](#) to help you plan and promote local outreach and educational events.

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