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BEHAVIORAL HEALTH UPDATE: July 2015
A Monthly Report for Members
of the American Hospital Association www.aha.org and the
National Association of Psychiatric Health Systems, www.naphs.org

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1. Supreme Court upholds subsidies through federally run ACA exchanges.
2. Reps. Murphy, Johnson introduce revised mental health bill.
3. MACPAC report to Congress examines Medicaid's role in providing behavioral health services.
4. AHA and NAPHS submit comments on proposed rule outlining FY16 inpatient psychiatric PPS update and quality measures.
5. AHA & NAPHS offer CMS suggestions on proposed rule on mental health parity in Medicaid and CHIP.
6. Resources available to help providers and consumers with parity implementation and appeals.
7. States have until Aug 5 to apply for demonstration created by *Excellence in Mental Health Act*.
8. ASAM releases national practice guideline for the use of medications in the treatment of addiction involving opioid use.
9. Reminder: Inpatient psychiatric facility quality reporting program data submission period begins July 1, 2015.
10. Emergency department guide provides tools for caring for adult patients with suicide risk.
11. FGI white paper explores common mistakes in designing psychiatric hospitals.
12. Psychiatric readmissions in community hospitals are the subject of an AHRQ statistical brief.
13. Report summarizes data on children's mental health.
14. Study reports rise in suicide among black children.
15. Analysis looks at health reform implementation as it impacts children, youth, and young adults with mental conditions.
16. CDC: 3.3% of adults had serious psychological distress in 2009-2013.
17. Data analysis looks at Medicaid and dual-eligible spending estimates for behavioral health.
18. Drug overdoses are leading cause of injury deaths, report finds.
19. DEA: More heroin-related deaths now than at any time in the last decade.
20. Underage drinking decreased from 2002 to 2013, report finds.
21. SAMHSA reports rise in ED visits involving narcotic pain reliever tramadol.

1. **SUPREME COURT UPHOLDS SUBSIDIES THROUGH FEDERALLY RUN ACA EXCHANGES.** In a 6-3 decision June 25, the U.S. Supreme Court ruled in *King v. Burwell* that federal subsidies are allowable in states that have federally run health insurance exchanges. Both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) issued statements applauding the decision. AHA President and CEO Rich Umbdenstock called the ruling "a significant victory for protecting access to care for many of those who need it…There were more than six million good reasons for it because it ensures continued access to health insurance subsidies for so many Americans." NAPHS President and CEO Mark Covall said that continuation of subsidies helps people with behavioral health disorders retain access. "More people than ever before – some 62 million overall – have received improved mental health and substance use coverage as a result of the *Affordable Care Act* and the federal parity law. This has been a long time coming." Through the *King v. Burwell* ruling, some six million Americans who purchased insurance through federal exchanges will retain subsidies for their health insurance coverage, which includes mental health/substance use coverage provided at parity. In addition to the population impacted by this ruling, the Medicaid expansion population continues to have mental health/substance use coverage as an essential health benefit that must be provided at parity. NAPHS "is pleased that hard-won behavioral health benefits that millions have just acquired will continue uninterrupted."

2. **REPS. MURPHY, JOHNSON INTRODUCE REVISED MENTAL HEALTH BILL.** Reps. Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX) have reintroduced a revamped *Helping Families in Mental Health Crisis Act*, H.R. 2646, which would make a number of changes to the nation's mental health system. The bill seeks to promote more scientific research into behavioral health treatment, expand access and improve treatment for patients with serious mental illness, develop strategies to increase the mental health and substance abuse workforce, and impose greater controls over the federal grant-making process. In addition, the bill would create an Assistant Secretary for Mental Health and Substance Use Disorders within the Department of Health and Human Services to coordinate programs across different agencies; eliminate the 190-day lifetime limit on inpatient psychiatric hospital services under Medicare; amend the Medicaid institution for mental disease (IMD) exclusion, allowing states to use Medicaid funding to cover IMD services; revise *Health Insurance Portability and Accountability Act* standards on the release of personal mental health information in emergency situations; and require the Government Accountability Office to study health plans' compliance with mental health parity laws. (Reps. Murphy and Johnson introduced similar legislation in December 2013.) On June 16, the House Energy and Commerce Committee's Subcommittee on Health held a hearing on H.R.2646 to examine the bill in detail. Complete testimony is available on the hearing website. To date there are 37 bipartisan cosponsors. Rep. Murphy has said that he hopes to move the bill soon.

3. **MACPAC REPORT TO CONGRESS EXAMINES MEDICAID'S ROLE IN PROVIDING BEHAVIORAL HEALTH SERVICES.** One in five Medicaid beneficiaries has a diagnosis of a behavioral health condition and these individuals' care accounted for almost half of total Medicaid expenditures, according to the Medicaid and CHIP Payment and Access Commission's (MACPAC's) June 2015 Report to Congress on Medicaid and CHIP. The analyses in the June report, which focus primarily on behavioral health, "represent MACPAC's first step in an extended inquiry into how to better manage and improve care for an especially at risk group of Medicaid beneficiaries," said MACPAC chair Diane Rowland. The report looks at the use of Medicaid services by beneficiaries with behavioral health conditions while also considering 1) the program's role in covering care for neglected and abused children and 2) the extent to which program beneficiaries are being prescribed psychotropic medications. The report points to low-income children under the protection of child welfare authorities as one group with high levels of unmet need for mental health care. According to the report, more than 40% of children in foster care had mental health diagnoses compared to 11% of other children with Medicaid. Nearly one-quarter of children enrolled in Medicaid based on child welfare assistance used a psychotropic medication, almost five times the share of other non-disabled children. The report's opening chapter also provides an overview of new Delivery System Reform Incentive Payment (DSRIP) demonstration projects underway in California, Massachusetts, New Jersey, New York, Ohio, and Texas. DSRIP programs are testing whether new uses for Medicaid supplemental payment can improve healthcare delivery if tied to achievement of specific milestones.

4. **AHA AND NAPHS EXPRESS CONCERNS TO CMS ON QUALITY MEASURES IN PROPOSED RULE OUTLINING FY16 INPATIENT PSYCHIATRIC PPS UPDATE.** In separate comment letters, the American Hospital Association (AHA) and the National Association of Psychiatric Health Systems (NAPHS) each voiced concerns to the Centers for Medicare and Medicaid Services (CMS) on quality measure proposals contained in a proposed rule outlining the Medicare program's Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) update for fiscal year 2016 (FY16). The proposed rule suggested adopting five new quality measures beginning with the FY18 payment determination. The AHA comment letter expressed concern that CMS continues to propose measures for the IPF Quality Reporting (IPFQR) Program that are not central to treating the psychiatric disorders for which patients have been admitted. "We urge CMS to work with IPF stakeholders to identify evidence-based measures that more appropriately assess the type of care that patients predominantly need and receive in these settings," wrote AHA Executive Vice President Rick

Pollack. The letter reiterates stakeholder concerns with a proposal to replace two transition of care measures with new measures that have not been tested in the psychiatric setting, and urges that any proposed readmissions measures be adjusted for sociodemographic factors. The NAPHS comment letter strongly recommended that the proposed discharge measure (0647) not be implemented because this domain of care is adequately covered by 42 CFR 482.43, Discharge Planning. "The proposed measure has not been studied in the IPF PPS population," NAPHS President/CEO Mark Covall wrote, and its implementation would be technically burdensome and duplicative of processes already in place in hospitals. "There is no data presented to demonstrate it would improve care." NAPHS also strongly recommended that the Timely Transmission of Transition Record (0648) not be implemented and that HBIPS-6 and HBIPS-7 be retained. "We would be open to working with the HBIPS measure steward (The Joint Commission) to refine the measure if there is a need to do so," NAPHS said. In addition, NAPHS recommended that any decision about the inclusion of a metabolic screening measure be delayed until the measure can be fully developed, tested, endorsed by the National Quality Forum, and evaluated for appropriateness for use in the IPFQR program.

5. **AHA AND NAPHS OFFER CMS SUGGESTIONS ON PROPOSED RULE ON MENTAL HEALTH PARITY IN MEDICAID AND CHIP.** In separate comment letters, both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) offered suggestions to the Centers for Medicare and Medicaid Services (CMS) on an April proposed rule to bring Medicaid and Children's Health Insurance Program plans into compliance with the *Mental Health Parity and Addiction Equity Act*. In the AHA comment letter, AHA Executive Vice President Rick Pollack called the proposed rule "an important step," but suggested CMS **"**exert greater oversight" to ensure that both state governments and Medicaid managed care organizations operating in the states comply with mental health parity standards. "Ensuring parity standards apply across all types of Medicaid and CHIP health plan benefit designs will help safeguard access to and the affordability of [mental health/substance use disorders] care for our nation's most vulnerable," he said. The law requires commercial health plans that offer mental health or substance use disorder benefits to provide them at parity with their medical/surgical benefits, thereby removing barriers to care and limitations on coverage affecting many patients. In the NAPHS comment letter, NAPHS President and CEO Mark Covall voiced strong support for the proposed approach "to apply parity to all beneficiaries enrolled in any form of managed care arrangements, including carve-outs and other types of alternative managed care arrangements." NAPHS recommended, among other things, that CMS find a way to shorten the proposed 18-month implementation timeline by phasing in certain requirements. NAPHS also asked CMS to include further clarifications and examples of how the application of non-quantitative treatment limits (NQTLs) can violate parity and better definitions of "long-term care," and "intermediate services."

6. **RESOURCES AVAILABLE TO HELP PROVIDERS AND CONSUMERS WITH PARITY IMPLEMENTATION AND APPEALS.** Two new resources are available to help both consumers and healthcare providers better understand the federal parity law (the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*) and how to take action on potential violations of the law. The Parity Implementation Coalition (PIC) and The Kennedy Forum have released the 2nd Edition of a Parity Resource Guide titled, "Simplifying the Appeals Process: Strategies for Winning Disputes with Your Health Plan." It includes tips on how to file parity appeals based on apparent violations of the federal parity law, medical necessity appeals, administrative or grievance appeals based on coverage limitations, and/or exclusions included in benefit plan documents. The guide also explains the external review appeals process available once all internal appeals have been exhausted. The guide is available for download at www.parityispersonal.org. A second resource, called ParityTrack, is a web-based site for mental health and substance use disorder parity information produced by the Kennedy Forum, Scattergood Foundation, and Treatment Research Institute. Reports analyze legislation, regulatory actions, and litigation at the federal and state levels.

7. **STATES HAVE UNTIL AUGUST 5 TO APPLY FOR DEMONSTRATION CREATED BY *EXCELLENCE IN MENTAL HEALTH ACT*.** The Substance Abuse and Mental Health Services Administration (SAMHSA) has begun the application process (RFA-SM-16-001) for states interested in being selected for a new demonstration program that will offer up to $24.6 million in planning grants to help states implement certification for Certified Community Behavioral Health Clinics**.** It will also establish prospective payment systems for Medicaid-reimbursable services at the clinics, according to SAMHSA. SAMHSA expects that up to 25 grantees will be provided up to $2 million in funding for up to one year (although actual award amounts may vary, depending on the availability of funds). The launch of the demonstration was also announced by Sens. Debbie Stabenow (D-MI) and Roy Blunt (R-MO), authors of the *Excellence in Mental Health Act* which created the demonstration and became law in April 2014. States must first apply for planning grants by August 5, and the recipients of those grants are expected to be announced in September. State agencies that are awarded the planning grants will work with interested community mental health centers, federally-qualified health centers, Veterans Administration clinics, and other mental health organizations to design a state proposal for participation. Eight state proposals will then be chosen to create a new demonstration program "to increase access to community mental health centers and improve the quality of care at those centers," the Senators said. Those programs could then be extended to other states, the Senators said.

8. **ASAM RELEASES NATIONAL PRACTICE GUIDELINE FOR THE USE OF MEDICATIONS IN THE TREATMENT OF ADDICTION INVOLVING OPIOID USE.** The American Society of Addiction Medicine (ASAM) has released its National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (Practice Guideline). The Practice Guideline "will assist clinicians prescribing pharmacotherapies to patients with addiction related to opioid use," according to a news release. "It addresses knowledge gaps about the benefits of treatment medications and their role in recovery, while guiding evidence-based coverage standards by payers." ASAM worked with Treatment Research Institute (TRI) to develop the Practice Guideline using the RAND/UCLA Appropriateness Method (RAM), a consensus process that combines scientific evidence with clinical knowledge. A multi-disciplinary Guideline Committee participated in the consensus process and helped write the guideline.

9. **REMINDER: INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING PROGRAM DATA SUBMISSION PERIOD BEGINS JULY 1, 2015**. The 2015 reporting period for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program runs from July 1 to August 15, 2015. Organizations are reminded that the program requires you to: 1) complete the *Quality Net* registration, if you have not done so; 2) complete a Notice of Participation (NOP) unless one is already on file (will carry over from year to year); 3) ensure that your facility has at least one (CMS recommends two) active *Quality Net* Security Administrator(s). If you are not sure of your security administrator (SA) status, call the Quality Net Help Desk at 866-288-8912; 4) collect and prepare to submit measure data between July 1- August 15, 2015; 5) after submitting data, complete the Data Accuracy and Completeness Acknowledgment (DACA) using the web-based tool accessible via the *Quality Net Secure Portal*. If you are an IPF and decide not to participate in the IPFQR Program, contact the IPFQR Support Contractor at 866-800-8765.

10. **EMERGENCY DEPARTMENT GUIDE PROVIDES TOOLS FOR CARING FOR ADULT PATIENTS WITH SUICIDE RISK.** The Suicide Prevention Resource Center (SPRC) has released a comprehensive emergency department (ED) guide titled Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments. The ED Guide provides evidence-based practices in decision support, initial interventions, and discharge planning for adults who have been identified as having some risk of suicide. According to the National Action Alliance for Suicide Prevention, ED-based interventions could reduce annual deaths from suicide by as much as 20%. The ED Guide

addresses specific objectives articulated by the 2012 National Strategy for Suicide Prevention (namely, to promote a continuum of care, safety, and well-being for ED patients treated for suicide risk; to collaborate with other healthcare providers to provide rapid and appropriate follow-up treatment; and to develop standardized protocols that direct clinical responses based on individual patient risk profiles).

11. **FGI WHITE PAPER EXPLORES COMMON MISTAKES IN DESIGNING PSYCHIATRIC HOSPITALS.** The Facility Guidelines Institute (FGI) has posted an updated white paper by safety experts James M. Hunt, AIA, NCARB, and David M. Sine, DrBE, CSP, ARM, CPHRM. The 2015 edition of Common Mistakes in Designing Psychiatric Hospitals: An Update was originally published in the American Institute of Architects Academy of Architecture for Health's Online Journal in 2009. It has since been updated to reflect significant changes since that time. The white paper can be accessed at http://www.fgiguidelines.org/beyond, where a link to the most recent 7.0 edition of the *Design Guide for the Built Environment of Behavioral Health Facilities* can also be found.

12. **PSYCHIATRIC READMISSIONS IN COMMUNITY HOSPITALS ARE THE SUBJECT OF AN AHRQ STATISTICAL BRIEF.** A statistical brief (#189) from the Agency for Healthcare Research and Quality's (AHRQ's) Healthcare Cost and Utilization Project (HCUP) found that 30-day readmission rates in 2012 were 15.7% when the primary diagnosis was schizophrenia and 9% when the primary diagnosis involved mood disorders. This compares with a 30-day readmission rate of 3.8% for all other non-mental health/substance abuse conditions. Hospital Readmissions Involving Psychiatric Disorders, 2012 is based on data from the HCUP Nationwide Readmissions Database and the HCUP National (Nationwide) Inpatient Sample, which both include short-term, non-Federal general hospitals. Psychiatric and alcoholism/chemical dependency hospitals are excluded.

13. **REPORT SUMMARIZES DATA ON CHILDREN'S MENTAL HEALTH.** An estimated 17.1 million American children have or have had a psychiatric disorder, according to a Children's Mental Health Report from the Child Mind Institute. That is more than the number of children with cancer, diabetes, and AIDS combined. "Children and adolescents with psychiatric illness are at risk for academic failure, substance abuse, and a clash with the juvenile justice system — all of which come at a tremendous cost to them, their families, and the community," the Child Mind Institute notes. The report summarizes national data on the commonness of childhood mental illness, the gap between illness and care, the cost to society of ignoring children's mental health, and the effectiveness of treatment. See http://childmind.org/speakup to view the report.

14. **STUDY REPORTS RISE IN SUICIDE AMONG BLACK CHILDREN.** Despite a stable overall suicide rate in school-aged children over the past 20 years, a national study reports that this trend "obscured a significant increase in suicide incidence in black children and a significant decrease in suicide incidence among white children." According to the *JAMA Pediatrics* analysis, the suicide rate among black children rose from 1.36 per one million children in 1993 to 2.54 by 2012, while the rate decreased in white children (from 1.14 to 0.77 per one millions children). "Findings highlight a potential racial disparity that warrants attention," the researchers conclude. "Further studies are needed to monitor these emerging trends and identify risk, protective, and precipitating factors relevant to suicide prevention efforts in children younger than 12 years."

15. **ANALYSIS LOOKS AT HEALTH REFORM IMPLEMENTATION AS IT IMPACTS CHILDREN, YOUTH, AND YOUNG ADULTS WITH MENTAL CONDITIONS.** The National Technical Assistance Center for Children's Mental Health at Georgetown University (TA Center), in collaboration with the National Association of State Mental Health Program Directors, has published an environmental scan that tracks implementation of health reform through the lens of services for

children, youth, and young adults with mental health conditions and their families. The 2015 scan is the third annual report in the TA Center's healthcare reform tracking project, which is designed to monitor and describe implementation of the *Affordable Care Act* (ACA) in states and the impact on children's mental health. Scan respondents are primarily children's mental health directors in each state. In some states, other individuals identified by the children's directors as most knowledgeable in this area were the respondents. The 2015 scan includes responses from 49 states, the District of Columbia, and Guam.

16. **CDC: 3.3% OF ADULTS HAD SERIOUS PSYCHOLOGICAL DISTRESS IN 2009-2013.** During 2009 to 2013, 3.3% of the civilian noninstitutionalized population aged 18 and over had serious psychological distress, according to a Centers for Disease Control and Prevention (CDC) data brief (NCHS Data Brief No. 203). In every age group, women were more likely to have serious psychological distress than men, said researchers who used data taken from the National Health Interview Survey. Among all adults, as income increased, the percentage with serious psychological distress decreased. Adults aged 18–64 with serious psychological distress were more likely to be uninsured (30.4%) than adults without serious psychological distress (20.5%). More than one-quarter of adults aged 65 and over with serious psychological distress (27.3%) had limitations in activities of daily living. Adults with serious psychological distress were more likely to have chronic obstructive pulmonary disease, heart disease, and diabetes than adults without serious psychological distress. Serious psychological distress was measured by a score of 13 or greater on the Kessler 6 (K6) nonspecific distress scale.

17. **DATA ANALYSIS LOOKS AT MEDICAID AND DUAL-ELIGIBLE SPENDING ESTIMATES FOR BEHAVIORAL HEALTH.** A Substance Abuse and Mental Health Services Administration (SAMHSA) report underscores the continuing impact of Medicaid in providing access and care for persons with mental health conditions and substance use disorders. Analyses of MAX Claims: SAMHSA Fee-for-Service Spending Estimates, Medicare-Medicaid Enrollee Analysis, and Managed Care Summary (SMA15-4908) was produced by SAMHSA's Center for Financing Reform and Innovation. The report examines Medicaid Analytic eXtract (MAX) data for 2008. It includes information on Medicaid fee-for-service spending for prescription drugs and provider type for all Medicaid enrollees. It describes spending for Medicare-Medicaid enrollees as compared with those who are not dually eligible. The report also describes an approach to determine spending for enrollees receiving care through managed care organizations. Along with future reports on MAX data from subsequent years, this report is intended "to help policymakers, program staff, and providers better understand spending on and utilization of services for mental health and substance use disorders. The report also will help SAMHSA to develop more precise estimates of state and federal spending on behavioral health."

18. **DRUG OVERDOSES ARE LEADING CAUSE OF INJURY DEATHS, REPORT FINDS.** Drug overdoses are the leading cause of injury deaths in the United States, at nearly 44,000 per year, according to a report titled The Facts Hurt: A State-By-State Injury Prevention Policy Report from the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF). These deaths have more than doubled in the past 14 years, and half of them are related to prescription drugs (22,000 per year). Overdose deaths now exceed motor vehicle-related deaths in 36 states and Washington, DC. In the past four years, drug overdose death rates have significantly increased in 26 states and Washington, DC and decreased in six.

19. **DEA: MORE HEROIN-RELATED DEATHS NOW THAN AT ANY TIME IN THE LAST DECADE.** "The threat posed by heroin in the United States is serious and has increased since 2007," according to the National Heroin Threat Assessment released by the U.S. Drug Enforcement Administration (DEA). Heroin is available in larger quantities, used by a larger number of people, and is causing an increasing number of overdose deaths, the report notes. In 2013, 8,620 Americans died

from heroin-related overdoses, nearly triple the number in 2010. "Heroin users today tend to be younger, more affluent, and more ethnically and geographically diverse than ever before," according to a DEA news release.

20. **UNDERAGE DRINKING DECREASED FROM 2002 TO 2013, REPORT FINDS.** Current underage drinking among those aged 12 to 20 decreased from 28.8% in 2002 to 22.7% in 2013, according to a report from the Substance Abuse and Mental Health Services Administration (SAMHSA). Underage Drinking Declined Between 2002 and 2013 is based on SAMHSA's National Survey on Drug Use and Health report, an annual national survey of 67,5000 Americans aged 12 and older. During that period, underage binge drinking – having five or more drinks on the same occasion – decreased from 19.3% to 14.2%. Despite the declines, Center for Substance Abuse Prevention (CSAP) Director Frances M. Harding said that "there are still 8.7 million current underage drinkers and 5.4 million current underage binge drinkers. This poses a serious risk not only to their health and to their future, but to the safety and well-being of others. We must do everything we can to prevent underage drinking and get treatment for young people who need it."

21. **SAMHSA REPORTS RISE IN ED VISITS INVOLVING NARCOTIC PAIN RELIEVER TRAMADOL.** Emergency department (ED) visits involving misuse or abuse of the narcotic pain reliever tramadol increased 250% between 2005 and 2011, with the largest increase among adults 55 and older, according to a report from the Substance Abuse and Mental Health Services Administration (SAMHSA). "Prevention efforts targeted to this population as well as their medical care providers may help reduce ED visits and subsequent hospitalizations, and should remain a public health priority," the report states. About half of the estimated 54,397 ED visits involving tramadol in 2011 were attributed to adverse reactions and 40% to misuse or abuse. The potential for adverse reactions underscores the importance of careful clinical management of patients prescribed the drug, according to a separate report on that issue. Tramadol is now the second most commonly prescribed narcotic pain reliever, outranking oxycodone in 2012.

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