==========

BEHAVIORAL HEALTH UPDATE: August 2016
A Monthly Report for Members
of the American Hospital Association www.aha.org and the
National Association of Psychiatric Health Systems, www.naphs.org

==========

1. CMS suspends partial hospitalization billing code edits that had been planned to start July 1.
2. IPF Quality Reporting deadline extended to August 26.
3. President signs legislation to address the opioid epidemic.
4. Final rule to increase cap on buprenorphine prescribing to 275 is among Administration initiatives announced on opioid crisis.
5. Governors sign compact to fight opioid addiction.
6. DEA report finds deaths involving heroin more than tripled between 2010 and 2014.
7. **Hospital OPPS proposed rule includes CY17 partial hospital rates and site-neutral recommendations; comments due September 6.**
8. New release of partial hospitalization PEPPER data available.
9. **Collaborative care model included in CMS proposed rule on CY17 physician fee schedule; comments due September 6.**
10. House passes mental health reform bill.
11. Senators call for improved transparency and enforcement of mental health parity.
12. AHRQ issues final evidence review on aggressive behavior in psychiatric patients.
13. Article discusses the $1 trillion link between mental health and economic productivity.
14. Report gives state estimates of past-year serious thoughts of suicide among young adults ages 18 to 25.
15. Decline in number of psychiatrists detailed in *Health Affairs* study.
16. Treatment Improvement Protocol provides an introduction to technology-based tools in behavioral health services.
17. AHRQ report examines effectiveness of telehealth.
18. American Telemedicine Association issues state report card on telemental health.
19. AHRQ releases playbook on integrating behavioral health care in ambulatory care settings.
20. CDC: Synthetic marijuana contributed to overdose cases from 2010-2015.
21. **Specialty drugs are among Medicaid's most costly outpatient drugs, report finds.**
22. September is National Recovery Month.

1. **CMS SUSPENDS PARTIAL HOSPITALIZATION BILLING CODE EDITS THAT HAD BEEN PLANNED TO START JULY 1.** The Centers for Medicare and Medicaid Services (CMS) has suspended enforcement of changes to its billing process for Partial Hospitalization Program services that were scheduled to begin July 1. The changes to the agency's Integrated Outpatient Code Editor would have enforced the program's minimum 20 hours per week of therapeutic services by requiring weekly billing and denying claims that did not meet the 20 hours in a given week. AHA, NAPHS, and others had urged CMS to drop the proposed edits, which are inconsistent with CMS guidance and regulation and would require substantial administrative and clinical changes by program providers.

2. **IPF QUALITY REPORTING DEADLINE EXTENDED TO AUGUST 26.** The submission deadline for data reporting for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Fiscal Year 2017 (FY17) has been extended from August 15 to Friday, August 26, 2016, at 11:59pm Pacific. The Centers for Medicare and Medicaid Services (CMS) encourages all participating hospitals to submit data at least two days prior to the deadline to allow time to address any submission issues. All IPF Prospective Payment System (IPF PPS) providers must meet all program requirements in order to qualify to receive their full Annual Payment Update (APU). Providers with an IPFQR Notice of

Participation (NOP) pledge status of "Participating" are required to submit measure data using the Web-Based Data Collection Tool (WBDCT) via the *QualityNet Secure Portal*. IPFs may direct questions to the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Team at https://cms-ip.custhelp.com or call 866-800-8765 or 844-472-4477. For additional background, see slides, a recoding, and a transcript of a July 7 training titled *IPFQR Program: Keys to Successful FY2017 Reporting,*

3. **PRESIDENT SIGNS LEGISLATION TO ADDRESS THE OPIOID EPIDEMIC.** Legislation designed to help stem the epidemic of opioid abuse through education, prevention, treatment, and rehabilitation has been approved by Congress and signed into law by President Obama. In July the House (407-5) and the Senate (92-2) approved the conference report for the *Comprehensive Addiction and Recovery Act* (S.524). President Obama signed the bill into law July 22. The measure includes, among other things, the creation of a multi-agency task force with a hospital representative that will develop best practices for prescribing and pain management; more stringent pre-market review of new opioids by the Food and Drug Administration; increased access to opioid overdose reversal drugs and medication-assisted treatment; and expanded research and treatment for vulnerable populations. **In a** statement**, the President** called the bill "modest" and said "some action is better than none." However, he said he was "deeply disappointed" in the absence of funding.

4. **FINAL RULE TO INCREASE CAP ON BUPRENORPHINE PRESCRIBING TO 275 IS AMONG ADMINISTRATION INITIATIVES ANNOUNCED ON OPIOID CRISIS.** Health and Human Services (HHS) Secretary Sylvia Mathews Burwell and National Drug Control Policy (ONDCP) Director Michael Botticelli recently outlined new Administration actions to address the prescription opioid and heroin epidemic and "the critical importance for Congress to approve the president's request of $1.1 billion to fight this nationwide epidemic." Among the announcements was publication of an HHS and Substance Abuse and Mental Health Services Administration (SAMHSA) final rule to increase from 100 to 275 the number of patients that qualified physicians who prescribe buprenorphine for opioid use disorders can treat. The "Medication-Assisted Treatment for Opioid Use Disorders" final rule, which is effective August 8, "aims to increase access to medication-assisted treatment and associated behavioral health supports for tens of thousands of people with opioid use disorders, while preventing diversion," the White House said. Also issued in the July 8 *Federal Register* is an accompanying proposed rule on reporting requirements for practitioners who are approved to treat up to 275 patients under the final rule. Comments on reporting requirements are due August 8. In addition, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) has issued a Request for Information (RFI) on "Opioid Analgesic Prescriber Education and Training Opportunities to Prevent Opioid Overdose and Opioid Use Disorder." ASPE is seeking "the most promising approaches in prescriber education and training programs and effective ways to leverage HHS programs to implement/expand them." Ideas are due to ASPE by September 6.

5. **GOVERNORS SIGN COMPACT TO FIGHT OPIOID ADDICTION.** Forty-six governors have signed a Compact to Fight Opioid Addiction, developed by and released through the National Governors Association (NGA). By signing the compact, governors are agreeing "to redouble their efforts to fight the opioid epidemic with new steps to reduce inappropriate prescribing, change the nation's understanding of opioids and addiction, and ensure a pathway to recovery for individuals suffering from addiction." According to the compact, possible actions include partnering with healthcare providers to develop or update evidence-based opioid prescribing guidelines; requiring opioid prescribers to receive training on pain management and addiction and use prescription drug monitoring programs; integrating state prescription drug monitoring program (PDMP) data into electronic health records; and reducing Medicaid and other health plan barriers to a range of treatment options. NGA said that the action "marks the first time in more than 10 years that governors have developed a compact through NGA to spur coordinated action on an urgent national issue."

6. **DEA REPORT FINDS DEATHS INVOLVING HEROIN MORE THAN TRIPLED BETWEEN 2010 AND 2014.** The number of U.S. deaths involving heroin more than tripled between 2010 and 2014 (from 3,036 to 10,574), according to a Drug Enforcement Administration (DEA) report. The DEA's 2016 National Heroin Threat Assessment Summary also found the number of people reporting current heroin use nearly tripled between 2007 and 2014 (going from 161,000 to 435,000). The number of users, treatment admissions, overdose deaths, and seizures from traffickers all increased over those reported in last year's summary. "We tend to overuse words such as 'unprecedented' and 'horrific,' but the death and destruction connected to heroin and opioids is indeed unprecedented and horrific," said DEA Acting Administrator Chuck Rosenberg. "The problem is enormous and growing, and all of our citizens need to wake up to these facts."

7. **HOSPITAL OPPS PROPOSED RULE INCLUDES CY17 PARTIAL HOSPITAL RATES AND SITE-NEUTRAL RECOMMENDATIONS; COMMENTS DUE SEPTEMBER 6.** The Centers for Medicare and Medicaid Services (CMS) has published a proposed rule on the hospital outpatient prospective payment system (OPPS), which includes partial hospital rates (see pages 45667-45678) that would be applicable to services furnished on or after January 1, 2017 (CY17). In the CY17 OPPS rule, CMS is proposing to replace the existing two-tiered APC structure for PHPs with a single APC by provider type (hospital-based or community mental health center) for providing three or more services per day. The single rate proposed for hospital-based PHPs in CY17 is $184.25, and the rate proposed for CMHCs is $129.45. [NOTE: Under the current payment structure in CY16, hospital-based PHPs receive $183.41 for 3 services and $212.67 for 4 or more services; and CMHC PHPs receive $94.49 for 3 services and $143.00 for 4 or more services.] Also addressed in the proposed rule is "site-neutral" payment, which would apply to hospital-based partial hospitalization programs (but not CMHCs that provide PHPs). Through the rule, CMS proposes to implement the site-neutral provisions of Section 603 of the *Bipartisan Budget Act of 2015*, which requires that (with the exception of dedicated emergency department services) services furnished in off-campus provider-based departments that began billing under the OPPS on or after November 2, 2015, would no longer be paid under the OPPS. These services would instead be paid under other applicable Part B payment systems beginning January 1, 2017. CMS proposes that, in 2017, the physician fee schedule (PFS) would be the applicable payment system for the site-neutral rates for the majority of services furnished in a new off-campus PBD. Specifically, CMS would pay physicians furnishing services in these departments at the higher "non-facility" PFS rate. There would be no payment made directly to the hospital by Medicare. Existing off-campus PBDs that expand their services to include those in new clinical families would receive the site-neutral rate for those services. In addition, any existing off-campus PBD that relocates after November 2 would lose its excepted status and be subject to site-neutral payments. An existing off-campus PBD that undergoes a change of ownership would only maintain its excepted status if the new owner accepts the existing Medicare provider agreement from the prior owner. AHA and NAPHS are analyzing the regulation in detail and will be providing comments to CMS, which are due September 6. A CMS news release and fact sheet on the proposed rule are online.

8. **NEW RELEASE OF PARTIAL HOSPITALIZATION PEPPER DATA AVAILABLE.** A new release of the Partial Hospitalization Program (PHP) Program for Evaluating Payment Patterns Electronic Report (PEPPER) with statistics through December 2015 is now available. PEPPER is an educational tool that summarizes provider-specific data statistics for Medicare services that may be at risk for improper payments. Freestanding PHPs can obtain their PEPPER through the PEPPER Resources Portal. PHPs administered by short-term acute care hospitals or inpatient psychiatric facilities received their PEPPER via the QualityNet secure portal. The PHP PEPPER will be available to download for approximately two years. If you have trouble accessing your PEPPER, contact the PEPPER Help Desk. To provide the field with additional background, go to the PHP Training and

Resources page at PEPPERresources.org, where you can also access the current PHP PEPPER User's Guide and a handout from a July 26 webinar.

9. **COLLABORATIVE CARE MODEL INCLUDED IN CMS PROPOSED RULE ON CY17 PHYSICIAN FEE SCHEDULE; COMMENTS DUE SEPTEMBER 6.** The Centers for Medicare and Medicaid Services (CMS) has "proposed changes to the Physician Fee Schedule (PFS) to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform," notes a CMS news release. The CMS proposed rule will be published in the July 15 *Federal Register*. Among various provisions in the CY17 PFS, CMS is proposing to pay for specific behavioral health services furnished using the Collaborative Care Model, which CMS says "has demonstrated benefits in a variety of settings. In this model, patients are cared for through a team approach, involving a primary care practitioner, behavioral health care manager, and psychiatric consultant." CMS is proposing to make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions, notes a CMS fact sheet. CMS is also proposing to pay more broadly for other approaches to behavioral health integration, according to a CMS blog. Comments on the proposed rule are due September 6.

10. **HOUSE PASSES MENTAL HEALTH REFORM BILL.** In July, the U.S. House of Representatives voted overwhelmingly (422-2) to approve H.R.2646, the *Helping Families in Mental Health Crisis Act.* Among other things, the bill would reauthorize suicide prevention programs and authorize a minority fellowship program for mental health professionals; codify a Medicaid managed care regulation allowing optional state coverage of Institutions for Mental Disease (IMD) services for adults; and require the Department of Health and Human Services to clarify the circumstances in which covered entities may disclose protected health information of a patient with mental illness. House Energy and Commerce Committee Chair Rep. Fred Upton (R-MI) said on the House floor that "this vote marks an important milestone in the multi-year, multi-Congress effort to deliver meaningful reforms to the nation's mental health system." Action by the full Senate will next be required to move the legislation toward enactment. The House bill has been referred in the Senate, and a separate Senate mental health bill (S.2680, the *Mental Health Reform Act of 2016*) is in the process of negotiations.

11. **SENATORS CALL FOR IMPROVED TRANSPARENCY AND ENFORCEMENT OF MENTAL HEALTH PARITY.** Eighteen Democratic Senators have said the White House should do more to make sure mental health parity laws are being enforced and people get equal access to treatment. In a letter to White House Domestic Policy Council Director Cecilia Muñoz, the lawmakers said the Mental Health and Substance Use Disorder Parity Task Force should consider the following when developing its recommendations: random audits and public disclosure of investigations into health plans' parity violations; collection of information on rates and reasons for claims denials; and requirements on health plans to provide information to providers. The Parity Task Force is required to present a report to the President by October 31.

12. **AHRQ ISSUES FINAL EVIDENCE REVIEW ON AGGRESSIVE BEHAVIOR IN PSYCHIATRIC PATIENTS.** The Evidence-based Practice Center (EPC) Program at the Agency for Healthcare Research and Quality (AHRQ) has completed an evidence review comparing the effectiveness of strategies to prevent and de-escalate aggressive behaviors in psychiatric patients in acute care settings, including interventions aimed specifically at reducing use of seclusion and restraint. Although the evidence did not support any specific recommendations, the report contains valuable information, including an extensive literature review. See the full report and an executive summary of "Strategies To De-escalate Aggressive Behavior in Psychiatric Patients."

13. **ARTICLE DISCUSSES THE $1 TRILLION LINK BETWEEN MENTAL HEALTH AND ECONOMIC PRODUCTIVITY. According to the World Health Organization (WHO), depression and anxiety disorders cost nearly $1 trillion annually. A recent Harvard Business School** article **points to a "groundbreaking" April WHO study that** established a definitive link between mental health and economic productivity. "On the upside," notes the Harvard article, "every dollar invested in treating those disorders leads to a return of $4 in terms of the ability to work and thus contribute to the economy." The article includes an interview with **Nava Ashraf,** an associate professor in the Negotiations, Organizations, and Markets unit at Harvard Business School, who **discusses the important link between mental health and economic productivity.**

14. **REPORT GIVES STATE ESTIMATES OF PAST-YEAR SERIOUS THOUGHTS OF SUICIDE AMONG YOUNG ADULTS AGES 18 TO 25.** Based on combined 2013–2014 National Surveys on Drug Use and Health (NSDUH), an estimated 2.6 million young adults aged 18 to 25 in the United States had serious thoughts of suicide in the past year. This is one of the findings in a Short Report from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Behavioral Health Statistics and Quality (CBHSQ). This translates to about 1 in 13 young adults (7.4% of the population) having suicidal thoughts in the past year. There were some differences across states (with rates of young adults with serious thoughts of suicide over the past year ranging from 6.2% in Texas to 10.3% in New Hampshire), the report found. 'Highlighting the prevalence of suicidal thoughts across states may help federal, state, and local policymakers continue to plan for and allocate resources to reduce the negative perceptions associated with mental and emotional issues, seek suicide prevention support, and increase access to mental health treatment," the report said.

15. **DECLINE IN NUMBER OF PSYCHIATRISTS DETAILED IN *HEALTH AFFAIRS* STUDY.** In 2003, there were 37,968 practicing psychiatrists in the U.S., according to a study in the July *Health Affairs* (35:1271-1277). By 2013, there were 37,889 (or a 10.2% reduction in the median number of psychiatrists per 100,000 residents in hospital referral regions). During this same time period, the number of primary care physicians and neurologists grew. "These findings may help explain why patients report poor access to mental health care," the authors note.

16. **TREATMENT IMPROVEMENT PROTOCOL PROVIDES AN INTRODUCTION TO TECHNOLOGY-BASED TOOLS IN BEHAVIORAL HEALTH SERVICES.** A new Treatment Improvement Protocol (TIP 60) titled Using Technology-Based Therapeutic Tools in Behavioral Health Services is now available from the Substance Abuse and Mental Health Services Administration (SAMHSA). The TIP addresses the shift toward electronic media and information technologies as it relates specifically to behavioral health services. "Technology-assisted care transcends some of the limitations of traditional practices, opening health practitioners and patients alike to new options in therapeutic care," SAMHSA notes.

17. **AHRQ REPORT EXAMINES EFFECTIVENESS OF TELEHEALTH.** There is sufficient evidence to support the effectiveness of telehealth for specific uses with some types of patients, including psychotherapy as part of behavioral health as well as remote patient monitoring, communication, and counseling for patients with chronic conditions. That is a key conclusion of an Agency for Healthcare Research and Quality (AHRQ) Technical Brief (#26) titled Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews. Among other things, the report calls for additional primary research on other telehealth topics. It also suggests integrating telehealth research into the evaluation of new models of care and payment.

18. **AMERICAN TELEMEDICINE ASSOCIATION ISSUES STATE REPORT CARD ON TELEMENTAL HEALTH.** A *State Telemedicine Gaps Report* from the American Telemedicine Association (ATA) identifies policy barriers "that impede the use of telemental and behavioral health

intended to enable patient and psychologist choice for quality healthcare services." In the state policy report, the ATA graded each state on psychologist-patient encounter, informed consent, and licensure and out-of-state practice. Eight states (Mississippi, Missouri, Nebraska, Nevada, Oklahoma, Texas, West Virginia, and Wisconsin) averaged a composite grade "A," indicating a supportive policy landscape that accommodates telemental telehealth adoption. Colorado was the only state that averaged the lowest composite score, "F," "suggesting there are many barriers for telemental health advancement within the state," the ATA said. "The GAPS report are an important tool for states to benchmark where they are in telehealth regulatory spectrum," said ATA CEO Jonathan Linkous. "By enabling states to clearly see where they rank relative to others, these states are then able to address each failing area one-by-one."

19. **AHRQ RELEASES PLAYBOOK ON INTEGRATING BEHAVIORAL HEALTH CARE IN AMBULATORY CARE SETTINGS.** The Agency for Healthcare Research and Quality's (AHRQ's) Academy for Integrating Behavioral Health and Primary Care has developed a new Integration Playbook as a guide to integrating behavioral health in primary care and other ambulatory care settings. The free guide provides tips, resources**,** and real-world examples of how practices are integrating behavioral health care; pitfalls to avoid; an interactive self-assessment checklist; and access to an online forum for peer-to-peer networking and sharing. While the focus is on primary care, ideas presented "can easily translate to medical specialties such as neurology, oncology, or occupational medicine," AHRQ notes. Additional Academy resources are also online.

20. **CDC: SYNTHETIC MARIJUANA CONTRIBUTED TO OVERDOSE CASES FROM 2010-2015.** Overdoses from synthetic marijuana rose in every region of the United States from 2010-2015, with the highest increases seen in the Northeast. This is a key finding in a Centers for Disease Control and Prevention (CDC) analysis in the July 15 *Morbidity and Mortality Weekly Report*. In Acute Poisonings from Synthetic Cannabinoids — 50 U.S. Toxicology Investigators Consortium Registry Sites, 2010–2015", the CDC says that the trend "underscores the importance of targeted prevention interventions and the need for education about the potentially life-threatening consequences of synthetic cannabinoid use." The report notes that "synthetic cannabinoids are two to 100 times more potent than cannabis, with exposure causing a range of mild to severe neuropsychiatric, cardiovascular, and other effects."

21. **SPECIALTY DRUGS ARE AMONG MEDICAID'S MOST COSTLY OUTPATIENT DRUGS, REPORT FINDS. A** new Kaiser Family Foundation (KFF) issue brief looks at which outpatient prescription drugs were most expensive to Medicaid and why. "Among the most costly drugs in aggregate used by the Medicaid program are drugs used to treat costly illnesses for which Medicaid is a key source of coverage, including behavioral health conditions (Abilify and Vyvanse)," states the report. The antipsychotic Abilify was the most expensive drug for state Medicaid programs from January 2014 through June 2015. Of the 50 most costly drugs, 45 fall into the high-cost category in part or primarily because they are frequently prescribed. Two opioids – hydrocodone-acetaminophen (the generic of Vicodin) and Suboxone (used to treat opioid use disorder) – fall into this category, as do several drugs used to treat attention-deficit and hyperactivity disorder.

22. **SEPTEMBER IS NATIONAL RECOVERY MONTH.** Every September, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors National Recovery Month to increase awareness and understanding of mental and substance use issues and celebrate the people who recover. Go to http://recoverymonth.gov/ for details. Also see a toolkit with resources to help you prepare to do community outreach throughout the coming month.

==========

This edition of Behavioral Health Update was prepared by Carole Szpak at comm@naphs.org.

Feel free to give us your feedback, stories: * NAPHS: Carole Szpak, NAPHS, comm@naphs.org, 202/393-6700, ext. 101 or AHA: Rebecca Chickey, AHA SPSAS, rchickey@aha.org, 312/422-3303