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BEHAVIORAL HEALTH UPDATE: May 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

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1. **FINAL RULE OUTLINES APPLICATION OF PARITY TO MEDICAID AND CHIP.** The Centers for Medicare and Medicaid Services (CMS) has issued a final rule applying certain provisions of the *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) to Medicaid managed care organizations, Medicaid alternative benefit plans (ABP), and the Children's Health Insurance Program (CHIP). These protections are expected to benefit more than 23 million beneficiaries. According to CMS, the final rule applies parity standards to coverage for Medicaid MCO, ABP, and CHIP enrollees so that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder (MH/SUD) benefits generally are no more restrictive than the requirements and limitations for medical and surgical benefits, among other provisions. In a change from the proposed rule, the final rule extends parity protections to long-term care services for MH and SUDs. The rule also requires that enrollees be provided information about the reasons for any reimbursement denial related to MH/SUD benefits. According to a Centers for Medicare and Medicaid Services (CMS) fact sheet, news release, and set of frequently asked questions, states will have up to 18 months after the date of the publication of the final rule (which was March 30) to comply with the finalized provisions.

2. **PRESIDENT CREATES PARITY TASK FORCE.** President Obama has signed a Memorandum creating an interagency parity task force, to be chaired by the Domestic Policy Council, "to advance access to mental health and substance use disorder treatment; promote compliance with best practices for mental health and substance use disorder parity implementation; and develop additional agency guidance as needed." The task force must report back by October 31 this year, which will allow time for new regulations and/or guidance to be issued before close of this Administration. The task force will work across federal departments and with diverse stakeholders.

3. **HHS PROPOSED RULE ON MEDICATION-ASSISTED TREATMENT WOULD INCREASE CAP ON BUPRENORPHINE PRESCRIBING.** A Department of Health and Human Services (HHS) and Substance Abuse and Mental Health Services Administration (SAMHSA) proposed rule published in the March 30 *Federal Register* would double the current patient limit for qualified physicians who prescribe buprenorphine to treat opioid use disorders. According to an HHS factsheet, the proposed rule would allow qualified practitioners to request approval to treat up to 200 patients a year if they have maintained an active waiver to treat up to 100 patients for a year and have subspecialty board certification in addiction medicine or addiction psychiatry, or practice in a qualified practice setting as defined in the rule. In addition, they would have to reaffirm their eligibility every three years; attest that they will adhere to evidence-based treatment guidelines; and provide or connect patients to necessary behavioral health services; among other conditions. The rule also would allow practitioners with a 100-patient limit to request to serve up to 200 patients for up to six months in an emergency. "The proposed rule aims to increase access to medication-assisted treatment and behavioral health supports for tens of thousands of people with opioid use disorders," the White House said. Comments are due May 31.

4. **CMS PROPOSED RULE INCLUDES UPDATED REQUIREMENTS FOR IPF QUALITY REPORTING PROGRAM.** The Centers for Medicare & Medicaid Services (CMS) has issued a fiscal year 2017 (FY17) proposed rule (CMS-1655-P) that includes updates to the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. The proposed rule is published in the April 27 *Federal Register*. The IPFQR Program requires both freestanding psychiatric hospitals and psychiatric units of acute care and critical access hospitals to report on quality measures or incur a two percentage point reduction in their annual payment update. CMS is proposing two additional measures to the IPFQR program beginning with the FY19 payment determination. The first new measure is "SUB-3, Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge" and the subset measure "SUB-3a, Alcohol & Other Drug Use Disorder Treatment at Discharge" (NQF #1664), a chart-abstracted measure that complements the previously adopted substance abuse measures in the IPFQR Program. The second new measure for FY19 will be "30-day all-cause unplanned readmission following psychiatric hospitalization in an IPF," which is a measure calculated from administrative claims data. "Due to increased interest in the IPF readmission measure," CMS has said it is providing a link to reference materials that describe the measure development process. In addition, CMS is proposing a technical update to the "Screening for Metabolic Disorder" measure. CMS also proposes to no longer specify two timeframes during the rulemaking process (namely, the approximate dates when the IPFs' 30-day *Hospital Compare* preview period will begin and the exact dates when the data will be publicly available on *Hospital Compare*). Instead, CMS proposes to use a sub-regulatory process to communicate publication and preview timeframes. Comments are due June 17.

5. **CMS TO ENFORCE THE MEDICARE PARTIAL HOSPITALIZATION PROGRAM'S 20-HOURS-PER-WEEK BILLING REQUIREMENT.** A Medicare Learning Matters Special Edition Article (SE1607) informs Outpatient Prospective Payment System (OPPS) providers submitting partial hospitalization program (PHP) claims to Medicare A/B Medicare Administrative Contractors (MACs) of its plans for enforcement of the PHP 20-hours-per-week billing requirement. The article conveys

enforcement editing requirements for the "Medicare Benefit Policy Manual," (Internet-Only Manual 100-02) Chapter 6, and Section 70.3 which describes coverage of Partial Hospitalization Program (PHP) Services. This guidance updates the operational mechanism PHP providers should use to bill Medicare for PHP services furnished on or after July 1, 2016. New editing will be implemented in the July 2016 quarterly release of the Integrated Outpatient Code Editor (IOCE). "This advance notice is being given to assist PHP providers to prepare for these changes," said the Centers for Medicare and Medicaid Services (CMS). Please ensure that your billing staff is aware of these changes.

6. **AHA AND NAPHS URGE SAMHSA TO ALIGN SUBSTANCE ABUSE CONFIDENTIALITY REQUIREMENTS WITH HIPAA.** In separate comment letters to the Substance Abuse and Mental Health Services Administration (SAMHSA), both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) recommended that a recent proposed rule be modified to align substance use disorder (SUD) privacy rules (under 42CFR Part 2) with current HIPAA (*Health Information Portability and Accountability Act*) rules. In the AHA comment letter, AHA Senior Vice President and General Counsel Mindy Hatton said that proposed revisions to the regulation governing the confidentiality of substance use disorder patient records do not eliminate current barriers that impede the sharing of information essential for clinical care coordination and population health improvement in today's patient care environment. The proposal should be reevaluated to determine how to best align the Part 2 regulation with current HIPAA rules "that permit patient information to be used and disclosed for treatment, payment and health care operations without having to obtain individual patient consents. It also will be essential for SAMHSA to work with Congress to eliminate any barriers in the statute underlying the Part 2 regulation that prevent full alignment," AHA said. In an NAPHS comment letter, NAPHS President and CEO Mark Covall said that aligning the privacy rules with HIPAA "would lead to a more integrated and streamlined process, which would clearly be in the spirit of parity and which would address the need to better integrate SUD with other medical conditions." NAPHS noted that "the perpetuation of the 42CFR Part 2 privacy structure results in an overemphasis of social harms related to disclosure of patients' clinical information in contrast to medical harm and overdose deaths related to poor coordination of care." A medical record without access to information on both mind and body is incomplete, NAPHS said. "Healthcare professionals need to access the whole record in order to treat the whole person."

7. **NEW PEPPER REPORT RELEASED; PEPPER WEBINAR TO BE HELD MAY 4.** A new release of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) – version Q4FY15 with statistics through September 2015 – has been made available through the QualityNet secure portal for inpatient psychiatric facilities (IPFs) and IPF distinct part units of short-term acute care and critical access hospitals. The PEPPER file(s) were recently uploaded to the AutoRoute_inbox of QualityNet account administrators and those with user accounts with the PEPPER recipient roles. Individuals who are QualityNet Administrators and who have PEPPER recipient role will receive the PEPPER file(s) twice. The PEPPER file(s) will be available for download in QualityNet for 60 days from the date it was uploaded. For the IPF PEPPER, there are three new target areas: 1) no secondary diagnoses; 2) one-day stays; and 3) no ancillary charges. There are two revised target areas: 1) the "comorbidities" target area now includes category 6 (oncology) comorbidities; and 2) the "30-day readmissions" target area now excludes discharge status codes 93 (discharge/transfer to IPF with planned acute care readmission) and 07 (LAMA). [NOTE: Partial hospitalization program (PHP) PEPPER reports will be distributed July 18 via Quality Net.] More information on the PEPPER initiative can be found at PEPPERresources.org. For individual assistance click on Help/ContactUs. In addition, on Wednesday, May 4, the TMF Health Quality Institute will offer a webinar titled "PEPPER Update Webinar for Inpatient Psychiatric Facilities and Partial Hospitalization Programs." The one-hour webinar begins at 1pm Central Daylight Time. Click here to join the event (with event number 925 498 422 and password bluebonnet). To connect by telephone, dial 1-415-655-0003 (toll). This

number will be active 10 minutes prior to the start of the session. A recording will be posted on the IPF and PHP Training and Resources sections of https://www.pepperresources.org/ by May 20.

8. **MEDICAID EXPANSION CAN IMPROVE BEHAVIORAL HEALTHCARE ACCESS, SAYS ASPE REPORT.** An estimated 1.9 million uninsured adults with mental illness or substance use disorders are eligible for Medicaid under the *Affordable Care Act* (ACA) but live in states that have not expanded coverage, according to a report ("Benefits of Medicaid Expansion for Behavioral Health") from the Department of Health and Human Services' (HHS') Office of the Assistant Secretary for Planning and Evaluation (ASPE). That's 28% of adults who would be eligible for Medicaid expansion in those states, HHS estimates. In addition to increasing access to treatment for these individuals, expanding coverage may reduce other medical costs, increase employment productivity, and lower overall rates of depression, the agency said. The report shows that "Medicaid expansion is an important step states can take to address behavioral health needs, including serious mental illness and opioid and other substance use disorders," said HHS Secretary Sylvia Burwell. Twenty states have yet to expand Medicaid eligibility under the ACA, although one (Louisiana) plans to do so in July.

9. **REPORT LOOKS AT STATE MEDICAID DIRECTORS' EFFORTS ON PAYMENT REFORM, INCLUDING VALUE-BASED PURCHASING.** "There are a number of value-based purchasing strategies focused on provider accountability in use by Medicaid programs," concludes a new report from the National Association of Medicaid Directors (NAMD). The report on *The Role of State Medicaid Programs in Improving the Value of the Health Care System* focuses on the three most widely used payment models: additional payments in support of delivery system reform, episode-based payments, and population-based payments. Because Medicaid is the largest payer for behavioral health services in the U.S., Medicaid "plays an important role in ensuring adequate access to high quality health care for the 20% of beneficiaries with a documented behavioral health diagnosis, and the countless more who are undiagnosed," the report says. "This role has been an impetus for state Medicaid programs to increasingly focus on including behavioral health services in alternative payment models." Among other things, the report tells state leaders that "there is value in bringing stakeholders [including providers] into the planning process for designing alternative payment models early."

10. **POLL: AMERICANS SEE SUBSTANCE ABUSE AS A MAJOR PROBLEM NEEDING ATTENTION.** In a recent nationwide poll of 1,042 adults conducted by The Associated Press-NORC Center for Public Affairs Research, few Americans say their communities are doing enough to deal with substance abuse, a problem that many see as particularly serious. Most Americans (62%) say at least one type of substance use is a serious problem in their community. Forty-three percent have a relative or close friend with substance abuse issues. The public also says more should be done to address the problem of substance use in their area. Seven in 10 Americans say their community is not doing enough to find improved methods of treating addiction (68%) or to make accessible treatment programs more available (69%). There is also strong public support for additional research and treatment options for substance use.

11. **AHRQ RELEASES NATIONAL DATA ON MENTAL AND SUBSTANCE USE DISORDERS AMONG HOSPITALIZED TEENAGERS.** At least one mental or substance use disorder was involved in more than one-fourth of hospital stays among teenagers in community hospitals in 2012, according to a Statistical Brief (#202, Mental and Substance Use Disorders Among Hospitalized Teenagers, 2012) from Agency for Healthcare Research and Quality's (AHRQ's) Healthcare Cost and Utilization Project. Among those 310,100 community hospital stays among teens ages 13 to 19, mood disorders were the most common mental disorder (with 199,200 stays), followed by anxiety disorders (85,800 stays), and attention and conduct disorders (81,700 stays). Cannabis use was the most common substance use disorder, with 54,100 stays), followed by alcohol use disorders

(27,500 stays) and opioid use disorders (14,500 stays). Hospital stays involving opioid use disorders were 40 times higher among 19-year-olds than 13-year-olds.

12. **POCKET GUIDE AVAILABLE ON MEDICATION-ASSISTED TREATMENT.** The Substance Abuse and Mental Health Services Administration (SAMHSA) has issued a pocket guide for health professionals titled *Medication-Assisted Treatment of Opioid Use Disorder*. The pocket guide offers guidelines for physicians using medication-assisted treatment for patients with opioid use disorder. It discusses the various types of approved medications, screening and assessment tools, and best practices for patient care.

13. **CDC ESTIMATES 1 IN 68 SCHOOL-AGED CHILDREN HAVE AUTISM.** An estimated 1 in 68 (14.6 per 1,000) school-aged children have been identified with autism spectrum disorder (ASD), according to a Centers for Disease Control and Prevention (CDC) report in the *Morbidity and Mortality Weekly Report (MMWR) Surveillance Summary*. Although this report shows essentially no change in ASD prevalence from an earlier 2014 report, "it is too soon to know whether ASD prevalence in the United States might be starting to stabilize," the CDC said. The CDC will continue tracking ASD prevalence to better understand changes over time. "What we know for sure is that there are many children living with autism who need services and support, now and as they grow into adolescence and adulthood," said Stuart K. Shapira, M.D., Ph.D., chief medical officer for CDC's National Center on Birth Defects and Developmental Disabilities. The report also underscores where efforts and resources can be directed to better support children and families with ASD. For example, black and Hispanic children continue to be less likely to be identified with ASD than white children, and they receive developmental evaluations later than white children, the CDC said.

14. **FEDERAL EMPLOYEE HEALTH PLAN TO IMPROVE AUTISM BENEFITS NEXT YEAR.** Starting in 2017, health plans participating in the Federal Employees Health Benefits Program (FEHBP) will be required to cover applied behavior analysis for children with Autism Spectrum Disorder (ASD). Rep. Chris Smith (R-NJ), the co-chairman of the Congressional Autism Caucus, said that "this decision is a milestone that will help ensure families across the country using ABA therapy will no longer have to pay the full out-of-pocket costs, and that public servants in every state will have access to an insurance plan that meets the needs of individuals on the spectrum." Rep. Smith noted that OPM had begun to encourage insurance providers to extend coverage of ABA through 'carrier letters' in recent years, but the uptake was slow. An OPM letter notifying carriers of the policy change said that "OPM has now determined that appropriate coverage of ABA treatment by all plans/options is necessary for the efficient and effective operation of FEHB's individual choice insurance model….We expect all carriers to offer clinically appropriate and medically necessary treatment for children diagnosed with ASD."

15. **IMPORTANT RULING IN ONGOING PARITY CLASS ACTION VS. HCSC.** The United States District Court for the Northern District of Illinois, Eastern Division, has denied Health Care Service Corporation's (HCSC's) motion to dismiss *Craft et al. v. HCSC*. The class action is being taken against HCSC, which is the largest customer-owned health insurance company in the U.S. operating the Blue Cross Blue Shield entities in Illinois, Texas, New Mexico, Montana, and Oklahoma. The case challenges both HCSC's categorical exclusion of residential treatment and the application of the Milliman Guidelines to residential treatment. The court order noted that "HCSC argues that the plain language of the Parity Act does not bar the RTC exclusions and that, on the contrary, it only prohibits quantitative limitations. Such a reading, however," said the court, "is belied by both the plain language of the statute and ordinary tools of statutory interpretation." Also noteworthy was the Court's unwillingness to penalize the plaintiffs for their inability to plead specific details with respect to the appropriate standards of care relevant to a parity analysis between medical/surgical and mental health benefits. Especially at the pleading stage, the court said, "patients are unlikely to be aware of the

potential range of 'recognized clinically appropriate standards of care' which may give rise to a difference in how mental health and medical services are treated and thus they would be left to speculate as to the clinical reasons for a particular disparity."

16. **PART 2 OF IPFQR Q&A TRANSCRIPT ON "NEW MEASURES AND NON-MEASURE REPORTING" NOW AVAILABLE.** The second part of a question and answer (Q&A) transcript for the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) webinar held January 21 on "New Measures and Non-Measure Reporting" is now available for download from www.QualityReportingCenter.com (under "IPFQR Program," then "Archived Events"). To maximize usefulness, questions received through the Chat feature during the event have been consolidated and focus on the most important and frequently asked questions. To obtain answers to questions that are not specific to the content of this webinar, refer to the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Manual or contact the Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Support Contractor (SC) at https://cms-ip.custhelp.com, 866/800-8765, or 844/472-4477.

17. **RECORDING NOW ONLINE OF IPFQR TRAINING ON "30-DAY ALL-CAUSE PLANNED READMISSIONS FOLLOWING PSYCHIATRIC HOSPITALIZATION" MEASURE.** A recording and slides are now online from an Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program training (originally presented on April 18) titled "Overview of the '30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF' Measure." The training provides background on the readmission measure and its development; the final measure specifications; how the measure compares to existing readmission measures; and future plans for the IPF readmission measure. This and other IPFQR archived trainings can be found at http://www.qualityreportingcenter.com/inpatient/ipf/events/.

18. **NIMH Q&A ON ELECTROCONVULSIVE THERAPY.** On March 17, the National Institute of Mental Health (NIMH) conducted a Facebook Q&A on electroconvulsive therapy (ECT). A summary of the Q&A is available online.

19. **GAO REPORT LOOKS AT WORKPLACE VIOLENCE.** The Government Accountability Office (GAO) was asked to review efforts by the Department of Labor's Occupational Safety and Health Administration (OSHA) to address workplace violence in health care. GAO examined the degree to which workplace violence occurs in healthcare facilities (including psychiatric hospitals) and OSHA's efforts to address such violence. OSHA is the federal agency responsible for protecting workers' safety and health, although states may assume responsibility under an OSHA-approved plan. OSHA does not require employers to implement workplace violence prevention programs, but it provides voluntary guidelines and may cite employers for failing to provide a workplace free from recognized serious hazards. In a new report (GAO-16-11 titled Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence, GAO recommends that "OSHA provide additional information to assist inspectors in developing citations, develop a policy for following up on hazard alert letters concerning workplace violence hazards in healthcare facilities, and assess its current efforts."

20. **BEHAVIORAL HEALTH ISSUES AFFECTING ASIAN-AMERICAN.** The Substance Abuse and Mental Health Services Administration (SAMHSA) recently released A Snapshot of Behavioral Health Issues for Asian American/Native Hawaiian/Pacific Islander Boys and Men: Jumpstarting an Overdue Conversation. The report highlights issues that are specific to Asian American, Native Hawaiian, and Pacific Islander (AANHPI) males. It provides clinicians with data on the prevalence of depression, suicide, and substance use disorder within the population.

21. **JUNE 1 IS DEADLINE TO NOMINATE PROGRAMS FOR APA'S 2016-2017 PSYCHIATRIC SERVICES ACHIEVEMENT AWARD.** The American Psychiatric Association (APA) is seeking nominations for its "Psychiatric Services Achievement Award" for 2016 and 2017. The award is presented to innovative programs that deliver services to the mentally ill or disabled, that have overcome obstacles, and that can serve as models for other programs. Each of four award recipients will be presented with a monetary award, a plaque, recognition at the APA's 2016 Institute on Psychiatric Services, and coverage in APA publications. Go to http://apapsy.ch/psychservicesaward for additional information and an application form. Direct questions to achievementawards@psych.org. June 1 is the application deadline.

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