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BEHAVIORAL HEALTH UPDATE: October 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 issued on medication-assisted treatment annual reporting requirements.
2. TRICARE final rule issued on "Mental Health and Substance Use Disorder Treatment."
3. AHA and NAPHS comment on hospital OPPS proposed rule that outlines site-neutral plans and CY17 partial hospitalization rates.
4. AHA and NAPHS support CMS plan to add Part B codes for collaborative care.
5. Social Security updates medical criteria used to evaluate disability claims involving mental disorders.
6. New York insurer settles $1.6 million in wrongful outpatient mental health denials.
7. Joint Commission details 2017 ORYX reporting requirements for accredited organizations; freestanding psychiatric hospitals continue to report four HBIPS measures.
8. Joint Commission reports on evidence and rationale for behavioral health care accreditation's eating disorders standards.
9. Two data reports provide details from latest National Survey on Drug Use and Health.
10. About 9.8 million American adults had serious thoughts of suicide in 2015, says SAMHSA report.
11. Report looks at ED visits involving suicide attempts that led to departures against medical advice.
12. SAMHSA offers printable version of its 2016 National Directory of Mental Health Treatment Facilities.
13. AHRQ summaries available on systematic review of psychosocial and pharmacologic interventions for disruptive behavior in children and adolescents.
14. Federal interagency group reports on key national indicators of children's well-being.
15. Report looks at trends in perception of risk and availability of substance use among full-time college students.
16. Reminder: October 6 is National Depression Screening Day.

1. **FINAL RULE ISSUED ON MEDICATION-ASSISTED TREATMENT ANNUAL REPORTING REQUIREMENTS.** The Substance Abuse and Mental Health Services Administration (SAMHSA) has issued a final rule outlining the reporting requirements for practitioners who are authorized to treat up to 275 patients with covered medications (medication-assisted treatment) in an office-based setting. The final rule will require practitioners to provide information on their annual caseload of patients by month, the number of patients provided behavioral health services and referred to behavioral health services, and the features of the practitioner's diversion control plan. These reporting requirements are intended to help the Department of Health and Human Services (HHS) ensure compliance with the requirements of the July 8 final rule ("Medication Assisted Treatment for Opioid Use Disorders"), which increased the cap on the number of patients to 275. The reporting requirements become effective October 27.

2. **TRICARE FINAL RULE ISSUED ON "MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT."** The Defense Department has published a final rule, effective October 3, titled "TRICARE: Mental Health and Substance Use Disorder Treatment." The rule "modifies the TRICARE regulation to reduce administrative barriers to access to mental health benefit coverage and to improve access to substance use disorder (SUD) treatment for TRICARE beneficiaries, consistent with earlier Department of Defense and Institute of Medicine recommendations, current standards of

practice in mental health and addiction medicine, and governing laws." The rule also "seeks to eliminate unnecessary quantitative and nonquantitative treatment limitations on SUD and mental health benefit coverage and align beneficiary cost-sharing for mental health and SUD benefits with those applicable to medical/surgical benefits, expand covered mental health and SUD treatment under TRICARE to include coverage of intensive outpatient programs and treatment of opioid use disorder and to streamline the requirements for mental health and SUD institutional providers to become TRICARE authorized providers, and to develop TRICARE reimbursement methodologies for newly recognized mental health and SUD intensive outpatient programs and opioid treatment programs."

3. **AHA AND NAPHS COMMENT ON HOSPITAL OPPS PROPOSED RULE THAT OUTLINES SITE-NEUTRAL PLANS AND CY17 PARTIAL HOSPITALIZATION RATES.** In separate comment letters, both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) urged the Centers for Medicare and Medicaid Services (CMS) to address the impact on Medicare partial hospitalization services of site-neutral provisions contained in the agency's proposed rule for the CY17 hospital outpatient prospective payment system (HOPPS). The AHA comment letter asks CMS to delay implementing the site-neutral provisions of the *Bipartisan Budget Act of 2015* until it can provide fair and equitable payment to hospitals for nonexcepted services (such as partial hospitalization). Among other changes to the proposed rule, AHA recommends that CMS allow excepted hospital outpatient departments to relocate and rebuild without triggering payment cuts; protect hospitals' ability to offer expanded lines of service without a loss of reimbursement; and allow hospitals to transfer ownership of individual HOPDs and maintain their excepted status. The AHA also recommends that new hospital-based PHPs that open on or after Nov. 2, 2015, as well as excepted PHPs that relocate or expand, be permitted to continue to bill under OPPS at the hospital-based PHP rate**.** The NAPHS comment letter urged CMS to adopt a "clear policy" that site-neutral provisions "do not apply to partial hospitalization programs (PHPs), including PHPs that may open after November 2, 2015 (non-excepted PHPs)….Absent such an exemption," wrote NAPHS, "CMS risks placing a moratorium on new PHP programs, which have no comparable 'physician office' service and are a critical and cost-effective level of care for Medicare beneficiaries living with mental illness." In addition, NAPHS expressed concern "about the dramatic and unexplainable significant decrease in the median cost calculated by CMS to be used as the basis for the 2017 PHP APC payment rate." NAPHS recommended that CMS use the median PHP cost from the 2016 rate year as the basis for the 2017 rate year. "If this freeze of the median cost is not acceptable to CMS," the letter said, "then NAPHS recommends a median cost phase-in of at least three years to allow PHP providers to assess their respective PHP programs and make operational changes as they deem appropriate to keep the programs in service."

4. **AHA AND NAPHS SUPPORT CMS PLAN TO ADD PART B CODES FOR COLLABORATIVE CARE.** In separate comment letters, both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) supported a proposal from the Centers for Medicare and Medicaid Services (CMS) to include a mechanism for Medicare to pay for care management services provided for the care of beneficiaries with behavioral health conditions, including services for substance use disorder treatment. Within the proposed rule on "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY17," CMS proposes new codes to pay for 1) services provided under the Psychiatric Collaborative Care Model (CoCM), in which a primary care team, consisting of a primary care provider and a behavioral health care manager, work in collaboration with a psychiatric consultant, such as a psychiatrist (GPPP1, GPPP2, GPPP3); and 2) care management costs incurred by primary care practices that treat patients with behavioral health conditions under behavioral health integration models other than the CoCM (GPPPX). The AHA comment letter notes that "the AHA is pleased that CMS is proposing policies to increase integration of behavioral services with primary care….Research shows that integration of behavioral health services and general medical care, such as through collaborative models, can reduce

costs and improve outcomes for these patients. We appreciate also that CMS's proposal is not limited to one model for behavioral health integration, but recognizes that providers may take different approaches to accomplishing this critical goal." The NAPHS comment letter noted that "the CMS proposal to – for the first time – implement a payment code under the physician fee schedule for non-face-to-face collaboration between primary care physicians and psychiatric specialists is an important first step." NAPHS also encouraged CMS "to continue to review other integrated care models (both inpatient and outpatient) so that reimbursement will be widely available for an effective service for Medicare and Medicaid beneficiaries."

5. **SOCIAL SECURITY UPDATES MEDICAL CRITERIA USED TO EVALUATE DISABILITY CLAIMS INVOLVING MENTAL DISORDERS.** In the September 26 *Federal Register*, the Social Security Administration (SSA) published a final rule to update the criteria used to evaluate disability claims involving mental disorders. The rule is effective January 17, 2017. The rule, titled *Revised Medical Criteria for Evaluating Mental Disorders*, is the "most comprehensive revision to the criteria since 1985," said the agency. In the rule, "we are revising the criteria in the Listing of Impairments (listings) that we use to evaluate claims involving mental disorders in adults and children under titles II and XVI of the *Social Security Act* (Act). The revisions reflect our program experience, advances in medical knowledge, recommendations from a commissioned report, and public comments we received in response to a Notice of Proposed Rulemaking." Throughout, the rule is updated to reflect information from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). "While updating this rule," said SSA, "the public had questions about our criteria for evaluating intellectual disability. From childhood onward, people with intellectual disabilities experience deficits in intellectual functioning and lack many basic daily practical and social skills. We decided it was critical to ensure these individuals receive necessary assistance as soon as possible. Therefore, we updated the diagnostic and functional criteria for this disorder and are using IQ test score criteria that will allow us to identify quickly people who may qualify for disability benefits based on an intellectual disability."

6. **NEW YORK INSURER SETTLES $1.6 MILLION IN WRONGFUL OUTPATIENT MENTAL HEALTH DENIALS.** The New York Attorney General has announced a settlement with HealthNow, New York, Inc., after an investigation "uncovered the wrongful denial of thousands of claims for outpatient psychotherapy and more than one hundred claims for nutritional counseling for eating disorders." The wrongful denials totaled more than $1.6 million in patient claims. Under the agreement, HealthNow (a not-for profit health service corporation providing healthcare coverage for approximately 573,700 New Yorkers, including 291,000 enrolled in commercial health plans) will pay members for the wrongfully denied claims, revise its policies, and eliminate a company policy that subjected all psychotherapy claims to review after a member's 20th visit. The investigation was launched under *Timothy's Law*, which mandates that New York group health plans provide "broad-based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments in adults and children at least equal to the coverage provided for other health conditions." The New York law is similar to the federal mental health parity law enacted in 2008.

7. **JOINT COMMISSION DETAILS 2017 ORYX REPORTING REQUIREMENTS FOR ACCREDITED ORGANIZATIONS; FREESTANDING PSYCHIATRIC HOSPITALS CONTINUE TO REPORT FOUR HBIPS MEASURES.** Freestanding psychiatric hospitals will continue to report four Hospital-Based Inpatient Psychiatric Services (HBIPS) measures (HBIPS-1, -2, -3, and -4) to meet Joint Commission ORYX performance measurement reporting requirements in 2017. This is highlighted in a Joint Commission Dear Colleague letter detailing all 2017 ORYX requirements.

8. **JOINT COMMISSION REPORTS ON EVIDENCE AND RATIONALE FOR BEHAVIORAL HEALTH CARE ACCREDITATION'S EATING DISORDERS STANDARDS.** The Joint Commission has released a new *R³ Report* on the new eating disorders standards for Behavioral Health Care Accreditation. The standards were released in January 2016 for residential and outpatient eating disorders programs. The new report provides a more in-depth rationale and evidence for the standards beyond what is in the accreditation manual. "With the new standards and the deeper knowledge provided in this report, we aim to provide Joint Commission accredited organizations with the tools they need to improve care and treatment for these individuals," said David W. Baker, M.D., M.P.H., F.A.C.P., executive vice president of The Joint Commission's Division of Health Care Quality Evaluation. The *R³ Report* provides details and references on the research undertaken to develop the standards and the reference sources (including practice guidelines from the American Psychiatric Association, practice parameters published in the *Journal of the American Academy of Child and Adolescent Psychiatry*, and published research) on the early recognition and medical risk management of eating disorders.

9. **TWO REPORTS PROVIDE DETAILS FROM LATEST NATIONAL SURVEY ON DRUG USE AND HEALTH.** The Substance Abuse and Mental Health Services Administration (SAMHSA) has issued two reports based on data from the latest (2015) National Survey on Drug Use and Health (NSDUH). According to the first report titled Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 NSDUH, there continues to be a significant treatment gap for mental and substance use disorders. For example, in 2015 an estimated 21.7 million people aged 12 or older needed substance use treatment, but only 2.3 million received treatment at a specialty facility. The report also shows that some forms of substance use – such as adolescent (aged 12 to 17) underage drinking and alcohol use among young adults (aged 18 to 25) – continued to drop. Other substance use levels among youth and young adults (including marijuana and heroin use) remained relatively stable over the past few years. The report also finds that mental illness levels among adults aged 26 and older generally remain steady, but there is a slight rise in the levels of major depressive episodes among adolescents and young adults. According to the second report titled Prescription Drug Use and Misuse in the United States: Results from the 2015 National Survey on Drug Use and Health, some 6.4 million people (among those aged 12 and older) currently (that is, in the past month) misuse psychotherapeutic medications. About three-fifths (59.3%) of this current misuse consists of the 3.8 million people currently misusing prescription pain relievers. The report also shows that most people who used prescription drugs in the past year did not misuse them. "In fact, 84.1% of them did not misuse prescription drugs even once in the past year," noted a SAMHSA news release. Detailed tables from the latest NSDUH are also online.

10. **ABOUT 9.8 MILLION AMERICAN ADULTS HAD SERIOUS THOUGHTS OF SUICIDE IN 2015, SAYS SAMHSA REPORT.** In 2015, four percent of American adults aged 18 and older thought seriously about killing themselves during the past 12 months from when they were surveyed. During this same period, 1.1% of adults made suicide plans, and 0.6% made non-fatal attempts at suicide. These are among the key findings in a Substance Abuse and Mental Health Services Administration (SAMHSA) report titled *Suicidal Thoughts and Behavior among Adults: Results from the 2015 National Survey on Drug Use and Health*. According to the report, people who drank alcohol and used illicit drugs in the past year had significantly higher levels of suicidal thoughts, making suicidal plans, and making nonfatal suicide attempts than the general adult population. For example, 9.8% of past-year alcohol and illicit drug users had serious suicidal thoughts compared to 4% of all adults. The report also shows that only about half (49%) of adults who had serious thoughts of suicide in the past 12 months received mental health services. People who made nonfatal suicide attempts had a higher rate of mental health treatment at 60.4%, SAMHSA said.

11. **REPORT LOOKS AT ED VISITS INVOLVING SUICIDE ATTEMPTS THAT LED TO DEPARTURES AGAINST MEDICAL ADVICE.** According to the Drug Abuse Warning Network, emergency department (ED) visits involving drug-related suicide attempts increased 41% from 2004 to 2011 (from an estimated 161,586 to 228,366 visits). This finding is reported in a new Substance Abuse and Mental Health Services Administration (SAMHSA) "Short Report" titled *Patients with Drug-Related Emergency Department Visits Involving Suicide Attempts Who Left Against Medical Advice*. The report notes that there were about 1.5 million ED visits involving drug-related suicide attempts between 2004 and 2011. Combined 2004 to 2011 data indicate that among the ED visits involving drug-related suicide attempts, 5,396 ED visits (less than 1%) ended with the patient leaving the ED against medical advice. Just over half (54%) of the ED visits involving drug-related suicide attempts that ended with the patient leaving against medical advice involved males, and over a quarter (29%) involved patients between the ages of 35 and 44. "Because release from the ED is a high-risk period for repeated suicide attempts and death by suicide," said the authors, "it is critical to provide outreach and mental health follow-up services to male and female patients whose suicide attempts involved drugs and who left the ED against medical advice." See SAMHSA's Suicide Prevention Resource Center for additional information on how EDs can best respond to patients with suicide risk.

12. **SAMHSA OFFERS PRINTABLE VERSION OF ITS 2016 NATIONAL DIRECTORY OF MENTAL HEALTH TREATMENT FACILITIES.** A printable version of the 915-page *National Directory of Mental Health Treatment Facilities 2016* is now available from the Substance Abuse and Mental Health Services Administration (SAMHSA). The directory lists federal, state, and local government facilities as well as private facilities that provide mental health treatment services. It includes treatment facilities that responded to the 2015 National Mental Health Services Survey (N-MHSS). If you have a facility to add or have changes to listings, please provide complete information to SAMHSA's directory contractor, Synectics (email: ibhs_help@smdi.com, phone: 1-888-301-1143, or mail: Synectics SAMHSA Directory Update, 1101 Wilson Boulevard, Suite 1500, Arlington, VA 22209). The 2016 directory is also available online at https://findtreatment.samhsa.gov in a searchable format with maps showing the location of each facility. Because the online listing is updated regularly, more current information may be available there than in the print version.

13. **AHRQ SUMMARIES AVAILABLE ON SYSTEMATIC REVIEW OF PSYCHOSOCIAL AND PHARMACOLOGIC INTERVENTIONS FOR DISRUPTIVE BEHAVIOR IN CHILDREN AND ADOLESCENTS.** New summaries are now available from the Agency for Healthcare Research and Quality's (AHRQ's) Effective Health Care Program (EHCP) from the systematic review of "Psychosocial and Pharmacologic Interventions for Disruptive Behavior in Children and Adolescents." The clinicians' summary is titled *Psychosocial and Pharmacologic Interventions for Disruptive Behavior Disorders in Children and Adolescents: Current State of the Evidence*. The consumer summary is titled *Treating Disruptive Behavior Disorders in Children and Teens*.

14. **FEDERAL INTERAGENCY GROUP REPORTS ON KEY NATIONAL INDICATORS OF CHILDREN'S WELL-BEING.** The 2016 edition of America's Children: Key National Indicators of Well-Being has been published by the Federal Interagency Forum on Child and Family Statistics, a working group of 23 federal agencies reporting data on conditions and trends related to child and family well-being. The report tracks 41 indicators of child well-being in seven domains: behavior (including alcohol and drug use), health (including adolescent depression). family and social environment (including child maltreatment), health (including insurance coverage), economic circumstances, physical environment and safety, and education. In the behavior domain, for example, the Forum said that the percentages of 10th- and 12th-graders in all racial and ethnic groups who binge drink (that is, have five or more alcoholic beverages in a row on a single occasion) were the lowest in

2015 since the survey began tracking this statistic in 1980. Among 12th-graders, Hispanic and white non-Hispanic students reported binge drinking at twice the rate of black non-Hispanic students.

15. **REPORT LOOKS AT TRENDS IN PERCEPTION OF RISK AND AVAILABILITY OF SUBSTANCE USE AMONG FULL-TIME COLLEGE STUDENTS.** While many full- and part-time college students are aware of the risks of substance use, "a large percentage of young adults still did not believe that they would have great risk of harm from substance use," according to a Short Report from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality (CBHSQ). Using data from the National Survey on Drug Use and Health (NSDUH), the authors reported that about a quarter of young adults did not perceive a great risk of harm from trying heroin, and more than one-third did not perceive great risk of harm from daily binge drinking. "Understanding trends in the perception of risk from using varying substances may be useful to policymakers, educators, and prevention program staff in making decisions about deploying prevention messages," the authors said. Also see a SAMHSA news release on the report.

16. **REMINDER: OCTOBER 6 IS NATIONAL DEPRESSION SCREENING DAY.** Our thanks to our members who are offering screenings in their local communities. More information on the annual outreach effort is online, along with a toolkit with social posts and images that can be used to promote the event.

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