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BEHAVIORAL HEALTH UPDATE: February 2017
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 CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS; COMMENTS DUE FEBRUARY 17 ON RELATED PROPOSED RULE.**
The Department of Health and Human Services' (HHS') Substance Abuse and Mental Health Services Administration (SAMHSA) published both a final rule and a supplemental notice of proposed rulemaking on the "Confidentiality of Substance Use Disorder Patient Records" in the January 18 *Federal Register*. (The *Federal Register* announced the final rule's effective date as February 17; however, it appears that this rule – as well all others that are not yet in force – will be delayed for at least 60 days by President Trump's recent freeze on unfinished regulations.) The final rule is intended to update and modernize confidentiality regulations (42 CFR Part 2) "and facilitate information exchange within new healthcare models while addressing the legitimate privacy concerns of patients seeking treatment for a substance use disorder," the agency said in the rule. "These modifications also help clarify the regulations and reduce unnecessary burden." As outlined in the final rule, SAMHSA will now allow any lawful holder of patient identifying information to disclose Part 2 patient

identifying information to qualified personnel for purposes of conducting scientific research if the researcher meets certain regulatory requirements. SAMHSA also permits data linkages to enable researchers to link to data sets from data repositories holding Part 2 data if certain regulatory requirements are met. SAMHSA will also allow a patient to consent to disclosing their information using a general designation to individual(s) and/or entity(-ies) (e.g., "my treating providers") in certain circumstances. This change is intended to allow patients to benefit from integrated health care systems. SAMHSA has also added a requirement allowing patients (who have agreed to the general disclosure designation) the option to receive a list of entities to whom their information has been disclosed, if requested. SAMHSA has updated and modernized the rule to address both paper and electronic documentation. In addition, SAMHSA is asking for additional clarifications and suggestions in their notice of proposed rulemaking (NPRM). Specifically, the NPRM requests feedback regarding "the important role of contractors, subcontractors and legal representatives in the healthcare system with respect to payment and health care operations." Comments on the NPRM are due February 17.

2. **ANTHEM TO DISCONTINUE PRE-AUTHORIZATION FOR OPIOID ADDICTION TREATMENT DRUGS, FOLLOWING PARITY SETTLEMENT WITH NEW YORK ATTORNEY GENERAL.** Anthem, the nation's second largest health insurer, will end its policy of requiring prior authorization for medication-assisted treatment (MAT) for opioid use disorder, according to a national settlement announced by New York Attorney General Eric T. Schneiderman. The agreement comes several months after the New York attorney general announced a similar agreement with Cigna. This policy change will apply not only to most Anthem members in New York, but nationally as well, he said. Anthem had required providers to submit a prior approval form for MAT coverage requests, which required the providers -- who had already received specific training regarding MAT and federal authorization to prescribe these drugs -- to answer numerous questions about the patient's current treatment and medication history. The attorney general's investigation revealed that Empire BCBS denied nearly 8% of the overall requests for coverage of MAT in 2015 and the first half of 2016. This subsequently caused significant delays in patients obtaining treatment for addiction – or patients never obtaining the treatment at all. In contrast to its policy for drugs to treat opioid use disorder, Empire BCBS does not require prior authorization for the majority of drugs it covers for medical conditions (including opioids such as fentanyl, morphine, tramadol, and oxycodone, when prescribed for pain). "These disparities are not consistent with the New York and federal mental health parity laws, which require health plans to cover mental health and substance use disorder treatment the same way they cover treatment for physical conditions," said Attorney General Schneiderman. Under the agreement, Empire BCBS will also launch an initiative to expand access to MAT for members in its New York service area.

3. **COMMENTS DUE FEBRUARY 10 ON PROPOSED IPFQR "MEDICATION RECONCILIATION ON ADMISSION" MEASURE.** Public comments are due February 10 on a measure ("Medication Reconciliation on Admission" or MUC16-49) under consideration for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. The Centers' for Medicare and Medicaid Services (CMS') IPFQR contractor, Health Services Advisory Group, Inc. (HSAG), is seeking comments concerning "the importance, relevance, scientific acceptability, and feasibility of the proposed measure," as well as general comments about the proposed measure. See draft measure documentation for background. The measure is being developed under the Inpatient Psychiatric Facility Outcome and Process Measure Development and Maintenance Project. "Once finalized, this measure may be proposed for adoption into the IPFQR program," HSAG said. The measure assesses the average completeness of three components of the medication reconciliation process within 48 hours of admission. The components include: 1) comprehensive prior to admission (PTA) medication information gathering and documentation; 2) completeness of critical PTA medication information; and 3) reconciliation action for each PTA medication. Background about the project and the proposed quality measure is online. Go to www.surveymonkey.com/r/MedRecMeasure to submit comments. If

you have technical difficulties submitting comments, contact Marie Hall at mhall@hsag.com. There are also two additional measures under consideration (see page 7 in document). These measures are "Continuation of Medications Within 30 Days of Inpatient Psychiatric Discharge" (MUC16-48) and "Identification of Opioid Use Disorder among Patients Admitted to Inpatient Psychiatric Facilities" (MUC16-428).

4. **COMMENTS DUE FEBRUARY 13 ON THE "PROTECTING OUR INFANTS ACT REPORT TO CONGRESS."** The Substance Abuse and Mental Health Services Administration (SAMHSA) recently announced the release of the *Protecting Our Infants Act* Report to Congress in the *Federal Register*. Mandated by Congress, this report includes four parts. Part 1 provides an overview of prenatal opioid exposure and neonatal abstinence syndrome (NAS). Part 2 provides a description of U.S. Department of Health and Human Services (HHS) surveillance, research, service delivery, education, and coordination activities for prenatal opioid exposure and NAS, as well as current gaps in HHS programs and recommendations for addressing them. Part 3 includes clinical recommendations for identifying, preventing, and treating prenatal opioid exposure and NAS. HHS is specifically seeking comments on Part 4, which outlines a strategy to address gaps, overlap, and duplication among federal programs, and to effectively address prenatal opioid exposure and NAS. Comments are due February 13 to http://www.regulations.gov (Docket No. SAMHSA-2016-0004). Relevant public comment will be incorporated into the final version of the report, which will be published on the HHS website by May 25, 2017.

5. **REMINDER: IPFs MUST INITIATE NHSN ENROLLMENT NO LATER THAN MARCH 3 IN ORDER TO REPORT IPF QUALITY REPORTING PROGRAM DATA ON INFLUENZA VACCINATION.** All facilities participating in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program must be enrolled with the National Healthcare Safety Network (NHSN) in order to submit Influenza Vaccination Among Healthcare Personnel (HCP) measure data. IPFs that are already enrolled with the NHSN are advised to log in well in advance of the deadline to avoid potential access issues later. IPFs that are not enrolled with the NHSN are advised to begin the enrollment process as soon as possible as the processing time is approximately four to six weeks. Failure to initiate enrollment with the NHSN prior to March 3, 2017, may jeopardize an IPF's ability to submit and verify submission of accurate Influenza Vaccination Among HCP measure data prior to the May 15, 2017, submission deadline. Failure to submit the data by May 15 may result in a two percentage point reduction in the IPF's fiscal year 2018 (FY18) annual payment update from the Centers for Medicare and Medicaid Services (CMS). Background resources include training slides on data submission, and resources for NHSN users already enrolled. (For additional background, also see an archived presentation of an IPFQR Outreach and Education webinar, originally held January 26, titled "IPFQR Program: Collecting and Entering Healthcare Personnel Influenza Vaccination Data.") Direct questions to the NHSN Help Desk at nhsn@cdc.gov. Be sure to include "IPF NHSN Enrollment" or "IPF HCP Measure Data Submission" in the subject line, as well as, the name and CMS Certification Number (CCN) of the facility in the body of the email.

6. **HOSPITAL COMPARE WEBSITE UPDATED WITH IPF QUALITY REPORTING DATA.** As of December 19, the Centers for Medicare and Medicaid Services (CMS) has updated the Hospital Compare website. Updates now include Inpatient Psychiatric Facility Quality Reporting (IPFQR) data. Direct questions regarding the *Hospital Compare* Overall Rating to cmsstarratings@lantanagroup.com.

7. **AHA AND NAPHS COMMENT ON 20-HOUR-WEEK REQUIREMENTS FOR PARTIAL HOSPITALIZATION INCLUDED IN HOSPITAL OPPS RULE.** In separate comment letters, both the American Hospital Association (AHA) and the National Association of Psychiatric Health Systems (NAPHS) urged the Centers for Medicare and Medicaid Services (CMS) to consider multiple factors when reviewing partial hospitalization program (PHP) requirements for 20-hours per week of

service. The letters were in response to the CMS CY2017 Hospital Outpatient Prospective Payment (OPPS) final rule with comment period. In the AHA comment letter, AHA Executive Vice President Thomas P. Nickels wrote that "the AHA agrees with CMS that patients eligible for PHP services should receive the appropriate intensity of services." If CMS finds a systemic and significant decline in the intensity of PHP services among providers, and so ultimately decides to implement a claims edit, "we strongly recommend that the policy include reasonable exceptions, not mandate weekly billing for PHP and not implement the edit in an administratively burdensome manner." In the NAPHS comment letter, NAPHS President and CEO Mark Covall also acknowledged the partial hospitalization program (PHP) requirement that patients must be able to cognitively and emotionally participate in the active treatment process and to tolerate the intensity of a PHP program. However, NAPHS noted that through the extensive experience of its members, "appropriately certified patients – with high levels of commitment to the program, with intensive and individualized plans of care, and with demonstrated clinical progress – are occasionally not able to fully participate in the weekly requirement of 20 hours of service for many reasons." NAPHS also supported the CMS decision to not require hospital-based off-campus partial hospitalization programs (PHPs) opened after November 2, 2015, to become community mental health centers (CMHCs) in order to be paid under the site-neutral provisions of the *Bipartisan Budget Act*.

8. **HHS: UNINSURED MENTAL HEALTH, SUBSTANCE USE HOSPITALIZATIONS FALL.** Only about 5% of adults in Medicaid expansion states who were hospitalized for substance use or mental health disorders in third-quarter 2015 lacked health insurance, down from 20% in 2013, according to a new report by the Department of Health and Human Services (HHS). Including non-expansion states, 11% of adults hospitalized for substance use or mental health disorders lacked health insurance in third-quarter 2015, down from 21% in 2013, HHS said. "The same trends have occurred in the states most affected by the opioid epidemic," HHS said

9. **AHRQ: EMERGENCY DEPARTMENT VISITS FOR MENTAL AND SUBSTANCE USE DISORDERS INCREASED SUBSTANTIALLY BETWEEN 2006 AND 2013.** The rate of emergency department (ED) visits per 100,000 population related to mental and substance use disorders (M/SUDs) increased substantially between 2006 and 2013, according to a new Statistical Brief (#216) from the Agency for Healthcare Research and Quality's (AHRQ's) Healthcare Cost and Utilization Project (HCUP). According to *Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013*, the rate of emergency department visits related to depression, anxiety, or stress reactions increased 56% between 2006 and 2013. During the same period visits related to psychoses or bipolar disorders increased 52%, while visits related to substance use disorders increased 37%. (Note: The analyses in the Statistical Brief were limited to patients aged 15 years and older. The report also provides further analyses by age and sex.)

10. **AHRQ STUDY FINDS OPIOID-RELATED HOSPITAL STAYS SOAR NATIONWIDE, BUT VARY WIDELY AMONG STATES.** Opioid-related hospital stays increased nationwide by 64% from 2005 to 2014, according to an Agency for Healthcare Research and Quality (AHRQ) report offering new insights into the nation's costly opioid epidemic. Trends in opioid-related hospital stays varied widely among states, with rates increasing more than 70% in North Carolina, Oregon, South Dakota and Washington, for example, while declining in Illinois, Kansas, Louisiana and Maryland. The report, *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009–2014*, features data from AHRQ's Fast Stats, an online resource that provides inpatient and emergency department data from AHRQ's Healthcare Cost and Utilization Project. "The rise in overdoses linked to opioids, including prescription painkillers and heroin, has been declared an epidemic" by the U.S. Department of Health and Human Services, AHRQ noted. HHS initiated several strategies to help Americans struggling with opioid addiction, including AHRQ's series of grants totaling $12 million to address delivering medication-assisted treatment for opioid abuse in rural primary care practices. For more

details, see a press release on AHRQ's report, an infographic that shows state variations in opioid-related hospital stays, and an AHRQ Views blog post on efforts to reduce opioid misuse.

11. ***DECISIONS IN RECOVERY* TOOL AVAILABLE TO SUPPORT TREATMENT AND RECOVERY FROM OPIOID USE DISORDER.** The Substance Abuse and Mental Health Services Administration (SAMHSA) has released an interactive, online shared decision-making tool for people with (or seeking recovery from) opioid use disorder and their service providers. The Decisions in Recovery web-based tool and its accompanying handbook are "designed to help people learn about treatment options for opioid use disorder so they can work with their healthcare providers in deciding what might work best for them," SAMHSA said. The tool can also be used by health officials, policymakers, and other community members involved in the problem of opioid use disorder. The tool includes easy-to-understand information about three primary medications used for medication-assisted treatment (MAT) of opioid use disorder (methadone, buprenorphine, and naltrexone) along with their outcomes, risks, and benefits. It also includes tools to help individuals in recovery identify and consider personal goals and preferences for their unique situations. Brief videos of recovery stories are included that provide a range of views and experiences from individuals in recovery and from service providers. Downloadable worksheets to assist anyone on their recovery are included. Go to https://www.samhsa.gov/brss-tacs/shared-decision-making for more information.

12. **EIGHT STATES TO PARTICIPATE IN MEDICAID'S CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DEMONSTRATION.** The Department of Health and Human Services (HHS) has announced the selection of eight states to participate in the Certified Community Behavioral Health Clinic (CCBHC) demonstration authorized under Section 223 of the *Protecting Access to Medicare Act of 2014*.. The eight states are Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. A key consideration in their selection, said HHS, was that participating states represented a diverse selection of geographic areas, including rural and underserved areas. Through the demonstration, certified community behavioral health clinics will be paid under a prospective payment system to provide evidence-based behavioral health services and supports to Medicaid and Children's Health Insurance Program beneficiaries. Participating clinics will coordinate care with primary care providers and hospitals in the community and report on quality measures. States will have until July 1, 2017, to begin their two-year demonstration programs.

13. **JOINT COMMISSION CLARIFIES THAT USE OF SECURE TEXT MESSAGING FOR PATIENT CARE ORDERS IS NOT ACCEPTABLE.** The Joint Commission recently clarified in their *Perspectives* that "use of secure text messaging for patient care orders is not acceptable" and is "not permitted at this time." After collaborating with the Centers for Medicare and Medicaid Services (CMS), The Joint Commission concurred that (although prior data privacy and security concerns had been addressed) "concerns remained about transmitting text orders even when a secure text messaging system in used." The Joint Commission and CMS are now recommending that all healthcare organizations should have policies prohibiting the use of unsecured text messaging—that is, short message services (SMS) text messaging from a personal mobile device—for communicating protected health information. They agree that computerized provider order entry (CPOE) should be the preferred method for submitting orders "as it allows providers to directly enter orders into the electronic health record (EHR). In the event that a CPOE or written order cannot be submitted, a verbal order is acceptable, they said. "The Joint Commission and CMS will continue to monitor advancements in the field and engage with key stakeholders to determine whether future guidance on the use of secure text messaging systems to place orders is necessary," notes the *Perspectives* article. In the meantime, direct questions to textingorders@jointcommission.org.

14. **FEBRUARY 9 WEBCAST KICKS OFF SERIES AIMED AT EDUCATING MEDIA ON BEST WAY TO TALK ABOUT SUBSTANCE USE.** A new webcast series, The Power of

Language and Portrayals: What We Hear, What We See, will launch in February to help change the way media talk about and portray substance use in news and entertainment. The series is produced by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT), with support from the Entertainment Industries Council, Inc. The webcast series aims to educate TV and radio producers, screenwriters, entertainment journalists and authors, as well as the public, on the best possible language to use when discussing substance use disorders. Four webcasts are planned: **February 9** on "Trauma and Peer Engagement; **March 23** on "Treatment and Recover—Research to Practice," **April 27** on "Inside Treatment and Recovery—A Look at the Transition," and **June 8** on "Substance Use Disorders and Other Health-Related Issues in Primary Care." Information on program login will be provided closer to webcast air dates. Webcasts will be made available after the initial air date on SAMHSA's YouTube Channel. See details on the webcasts and a SAMHSA blog.

15. **LABOR DEPARTMENT'S EBSA SUMMARIZES ITS 2016 PARITY ENFORCEMENT ACTIVITIES.** The Department of Labor's Employee Benefits Security Administration (EBSA) has posted a summary of actions the agency took in fiscal year 2016 (FY16) to enforce the federal parity law (the *Mental Health Parity and Addiction Equity Act*, or MHPAEA). EBSA enforces the law governing 2.2 million private employment-based group health plans, which cover 130.8 million participants and beneficiaries. According to the FY2016 MHPAEA Enforcement Fact Sheet, 191 closed health investigations in FY16 (out of a total of 330) involved plans subject to MHPAEA that were reviewed for MHPAEA compliance. Of these, EBSA cited 44 violations for MHPAEA noncompliance. The fact sheet includes examples of the types of violations EBSA uncovered. EBSA encourages individuals who believe their mental health or substance use disorder benefits were denied improperly to visit the Mental Health and Addiction Insurance Help Consumer Portal.

16. **KAISER'S 50-STATE SURVEY OF MEDICAID ELIGIBILITY AND ENROLLMENT POLICIES OFFERS A BASELINE FOR MEASURING FUTURE CHANGES.** As a new administration and Republican-led Congress begin a new term and seek to repeal the *Affordable Care Act* (ACA), a new 50-state survey from the Kaiser Family Foundation (KFF) offers an in-depth profile of Medicaid and Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal, and cost-sharing policies in each state as of January 2017. The document is intended to provide "a baseline against which future policy changes may be measured," the KFF said.

17. **AHRQ ISSUES FINAL REPORT ON STRATEGIES TO IMPROVE MENTAL HEALTH CARE FOR CHILDREN, ADOLESCENTS.** The Effective Health Care (EHC) Program of the Agency for Healthcare Research and Quality (AHRQ) has released a final report on Strategies to Improve Mental Health Care for Children and Adolescents. "Our findings," said researchers, "suggest that several approaches can improve both intermediate and final health outcomes and resource use. Twelve of the 17 included studies (11 of the 16 strategies) significantly improved at least one such outcome or measure."

18. **SAMHSA PUBLICATION EXPLORES THE CASE FOR BEHAVIORAL HEALTH SCREENING IN HIV CARE SETTINGS.** A report from the SAMHSA-HRSA Center for Integrated Health Solutions looks at The Case for Behavioral Health Screening in HIV Care Settings. The Substance Abuse and Mental Health Services Administration (SAMHSA) noted that the report "lays out the clear need for HIV treatment providers to jointly address behavioral health concerns and HIV, starting with screening for mental health and substance use disorders." The report offers strategies for providers to implement screening practices, including tips for preparing staff, updating organizational culture, and enhancing organizational infrastructure.

19. **AHA SECTION FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES NAMES 2017 LEADERS.** Ann Schumacher, president of CHI Health Immanuel Medical Center in Omaha, NE, is 2017 council chair of the AHA's Constituency Section for Psychiatric and Substance Abuse Services. Mary Lou Mastro, system CEO for Edward-Elmhurst Health in Elmhurst, IL, is council chair-elect and will become chair in 2018. The council works with the AHA to identify ways to define and focus AHA policy, advocacy and member resources to improve the quality, efficiency and delivery of psychiatric and substance abuse services. For more on the constituency section and its 18-member council, see the AHA news release.

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