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BEHAVIORAL HEALTH UPDATE: July 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. AHA and NAPHS comment on proposed IPF Quality Reporting Program changes.
2. IPFQR data submission period runs from July 1 to August 15.
3. IPFQR program issues new and updated tools to help with data collection and submission.
4. Joint Commission issues guidance on ligature risks.
5. New parity guidance issued by Labor Department; comments on a draft model disclosure template due September 13.
6. Federal court certifies California-wide mental health class action on parity.
7. Center for Mental Health Services names senior medical advisor.
8. HHS announces $70 million in funding to address the opioid crisis.
9. MACPAC report highlights role of Medicaid in responding to the opioid epidemic.
10. AHRQ examines patient characteristics of opioid-related hospital stays and ED visits.
11. New "Behavioral Health Barometer" provides a snapshot of key national data on behavioral health.
12. Report focuses on "Advancing Best Practices in Behavioral Health for Asian American, Native Hawaiian, and Pacific Islander Boys and Men."
13. Report: "A Day in the Life of Older Adults: Substance Use Facts."
14. Redesigned Learning Center now available for National Registry of Evidence-Based Programs and Practices.
15. APA national poll finds Americans show strong support for mental health coverage.

1. **AHA AND NAPHS COMMENT ON PROPOSED IPF QUALITY REPORTING PROGRAM CHANGES.** In separate comment letters, both the American Hospital Association (AHA) and National Association of Psychiatric Health Systems (NAPHS) provided feedback to the Centers for Medicare and Medicaid Services (CMS) on a proposed rule updating requirements for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. The proposed rule seeks to add one measure – Medication Continuation following Inpatient Psychiatric Discharge – for inclusion in the 2020 payment year. The measure is based on whether patients on Medicare (parts A, B, and D) with specific diagnoses fill a prescription for an appropriate medication within 30 days of discharge from the hospital. The AHA comment letter recommended that "CMS should not finalize this measure unless and until it has been recommended for inclusion in the IPFQR program by the MAP [Measure Application Partnership] and endorsed by the NQF [National Quality Forum]." Medication adherence is critical to ensuring positive outcomes, the AHA wrote, "however, we do not believe that a measure assessing whether patients have their prescriptions filled within a certain time period, including 30 days *post-discharge,* qualifies a hospital (facility) measure." The NAPHS comment letter also responded to a CMS call for topics for future consideration. NAPHS suggested that CMS develop "a standardized perception of care measure that is specific to the psychiatric hospital setting." Another topic for future consideration is safety planning with patients who have suicidal ideation. "We recommend that population screening measures (such as the SUB, TOB) be eliminated from the measure set currently in use." NAPHS supported the National Quality Forum's (NQF's) recommendation that these measures be deleted so the set can more sensitively represent the quality of psychiatric specialty care delivered in psychiatric facilities. NAPHS recommended that the metabolic screening measure be submitted to NQF "since it would provide feedback from the technical experts appointed by NQF and could address some of the concerns that continue to exist about the measure as currently specified." NAPHS also supported NQF's recommendation that the Follow-Up After Hospitalization for Mental Illness (FUH)

measure be removed from the list of measures for federal programs until it is re-specified for acute care and submitted for NQF endorsement. NAPHS expressed concerns about the complexity of the transition measures and whether they are appropriate for the psychiatric setting.

2. **IPFQR DATA SUBMISSION PERIOD RUNS FROM JULY 1 TO AUGUST 15.** The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program data-submission period is scheduled to begin on July 1 and end on Tuesday, August 15 at 11:59 pm Pacific. To successfully submit data prior to August 15, inpatient psychiatric facilities (IPFs) must perform the following tasks. First, ensure that the facility has at least one active *QualityNet* Security Administrator (SA). If you are not sure of your SA status, contact the *QualityNet* Help Desk at qnetsupport@hcqis.org or 866/288-8912. Second, have an IPFQR Program Notice of Participation (NOP) status of "Participating" on file. An IPF's NOP status can be verified on the *QualityNet Secure Portal*. Note that an existing NOP status will carry over from one year to the next, unless a change is submitted on the *QualityNet Secure Portal*. IPFs that decide not to participate in the IPFQR Program should contact the IPFQR Program Support Contractor at IPFQualityReporting@hcqis.org or by phone (866/800-8765 or 844/472-4477) to discuss the facility's next steps. Please note that IPFs can meet the active SA and NOP "Participating" status requirements at any time and do not need to wait until the beginning of the reporting period. CMS strongly encourages IPFs to complete these requirements as soon as possible. Refer to the IPFQR Program manual for further SA and NOP guidance, as well as information pertaining to FY18 data-submission requirements. In addition, see the archived IPFQR webinar (originally presented June 20) titled "IPFQR Program: Keys to Successful FY2018 Reporting."

3. **IPFQR PROGRAM ISSUES NEW AND UPDATED TOOLS TO HELP WITH DATA COLLECTION AND SUBMISSION.** New and updated tools are available on the IPFQR Program Resources and Tools webpage of the Quality Reporting Center website to assist facilities participating in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program in in the collection and successful submission of data for the fiscal year FY 2018 data-submission period and beyond. First, the *IPFQR Program Manual* provides a comprehensive overview of the IPFQR Program and measure specifications and gives step-by-step instructions to register on the *QualityNet Secure Portal*, submit data using the web-based measures application, and understand Preview Report processes. Key updates to the Manual are described in the Release Notes, Version 3.0, which include (but are not limited to) the following: 1) assigned version numbers to the current and previous manuals; 2) measure abstraction clarification for the following measures (Transition Record with Specified Elements Received by Discharged Patients; Timely Transmission of Transition Record; and Screening for Metabolic Disorders); and 3) updated guidance for downloading reports from the *Hospital Compare* website. Second, *IPFQR Program Abstraction Tools* provide an *optional*, informal abstraction mechanism to assist IPFs in the collection of data for the IPFQR Program. Updated HBIPS-2 and -3 Paper Tools are now available. Content and format of the event tracking tools have been updated to facilitate data collection for the measures. The Tools are for data to be submitted summer of 2017 and 2018. Third, the *Claims-Based Measure Specifications* document provides detailed specifications about the Follow-Up After Hospitalization for Mental Illness (FUH) and 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) measures. This document was updated with input from the measure developer.

4. **JOINT COMMISSION ISSUES GUIDANCE ON LIGATURE RISKS.** On May 31, The Joint Commission posted a Standards FAQ for hospitals and hospital clinics on "Ligature Risks – Assessing and Mitigating Risk for Suicide and Self-Harm." The FAQ responds to the question of "What are the Joint Commission expectations for identifying and managing ligature risks in the hospital setting?" and provides additional resources on the topic. It details requirements for inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units designated

for the treatment of psychiatric patients (i.e., special rooms/safe rooms in emergency departments or medical units).

5. **NEW PARITY GUIDANCE ISSUED BY LABOR DEPARTMENT; COMMENTS ON A DRAFT MODEL DISCLOSURE TEMPLATE DUE SEPTEMBER 13.** The Labor Department's Employee Benefits Security Administration (EBSA) has issued a new set of Frequently Asked Questions (FAQs Part 38) related to the implementation of the federal parity law (the *Mental Health Parity and Addiction Equity Act,* or MHPAEA). The new parity FAQ summarizes all the guidance that has been issued thus far on disclosure of plan information necessary to perform parity compliance testing. A new FAQ on eating disorder treatment reaffirms that MHPAEA applies to eating disorder treatment. The FAQ also requests comments on a new draft model form that plan participants can use to request information from their plan as part of their requirement under the *21st Century Cures* law. Additional detail on the information collection request is available online. Comments on the model form are due by September 13.

6. **FEDERAL COURT CERTIFIES CALIFORNIA-WIDE MENTAL HEALTH CLASS ACTION ON PARITY.** There has been a significant ruling in the fight for access to mental health care. On June 15, the United States District Court for the Northern District of California certified a California-wide ERISA class action against Blue Shield of California and Human Affairs International of California (a subsidiary of Magellan Health). The lawsuit alleges that the defendants breached their fiduciary duties of loyalty, prudence, and care to their insureds by developing, approving, and applying medical necessity criteria that are inconsistent with generally accepted standards for intensive outpatient and residential treatment. The plaintiffs' health plans require the defendants to evaluate medical necessity pursuant to generally accepted standards of care, which defendants have publicly represented are reflected by Magellan's proprietary guidelines. The plaintiffs allege that the defendants' interests in profitability led them to develop and apply medical necessity criteria that overemphasize acute symptoms to the exclusion of meaningful treatment for chronic and pervasive mental health and substance use disorders. A similar case against United Behavioral Health was certified as a nationwide class action by the United States District Court for the Northern District of California in September 2016, and trial in that matter is set for October 2017.

7. **CENTER FOR MENTAL HEALTH SERVICES NAMES SENIOR MEDICAL ADVISOR.** Child and adolescent psychiatrist Justine Larson, M.D., M.P.H., M.H.S., has been appointed as the new Senior Medical Advisor to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services (CMHS). According to a SAMHSA blog, Dr. Larson will begin work in September. She will work closely with SAMHSA's Chief Medical Officer Anita Everett, M.D., and across federal departments and agencies, "to ensure federal coordination in the provision of effective treatment and services for people with serious mental illnesses." With academic, research, and practice-based experience (particularly in the areas of child and adolescent mental health, evidence-based treatment, and integrated care), "Dr. Larson's expertise and leadership will be invaluable in applying a clinical lens across a broad spectrum of mental health programs." Among other things, she has been an active member with the American Academy of Child and Adolescent Psychiatry (AACAP) and served as co-chair of the Committee on Systems of Care for youth with serious emotional disturbances.

8. **HHS ANNOUNCES $70 MILLION IN FUNDING TO ADDRESS THE OPIOID CRISIS.** The Department of Health and Human Services (HHS) has announced more than $70 million in new funding opportunities to prevent and treat opioid use disorders and deaths. The grants include up to $28 million to help states increase access to medication-assisted treatment; $41.7 million to help local governments and tribal organizations train and provide resources to administer emergency treatment through first responders; and $1 million to improve access to overdose treatment. Applications for each

of these grant programs is July 31. In addition, HHS recently announced up to $3.3 million for a state pilot program to treat pregnant and postpartum women with substance use disorders, and up to $2.6 million to increase recovery support for substance abuse and addiction. July 3 is the application deadline for these two grant programs.

9. **MACPAC REPORT HIGHLIGHTS ROLE OF MEDICAID IN RESPONDING TO THE OPIOID EPIDEMIC.** Nationally, Medicaid beneficiaries are disproportionately affected by the opioid epidemic, according to the June 2017 *Report to Congress on Medicaid and CHIP* from the Medicaid and CHIP Payment and Access Commission (MACPAC). According to a MACPAC news release, Medicaid beneficiaries are prescribed pain relievers at higher rates than those with other sources of insurance; and they have a higher risk of overdose from prescription opioids, heroin, and fentanyl. But they are also more likely to receive treatment. Adults with Medicaid coverage are about three times more likely to have received substance use disorder treatment as inpatients, and almost twice as likely as privately insured adults to have received outpatient treatment. Chapter 2 of the report details how states (in addition to covering medication-assisted treatment) are working to reduce overprescribing and misuse of opioids. "The report highlights how states such as Vermont, Virginia, Ohio, and Texas are making innovative use of Medicaid legal authorities to expand treatment and integrate physical health and substance use disorder delivery systems," the MACPAC release notes. "Yet because many Medicaid addiction services are optional, states vary considerably in the services they cover and many Medicaid enrollees are still not receiving treatment." Additionally, Chapter 1 in the report addresses Medicaid coverage and spending for optional eligibility groups and benefits, and Chapter 3 assesses federal and state activities to ensure program integrity in Medicaid managed care, now the dominant delivery system in Medicaid.

10. **AHRQ EXAMINES PATIENT CHARACTERISTICS OF OPIOID-RELATED HOSPITAL STAYS AND ED VISITS.** "Between 2005 and 2014 there was a dramatic increase nationally in hospitalizations involving opioids: the rate of opioid-related inpatient stays increased 64%, and the rate of opioid-related emergency department (ED) visits nearly doubled." This is one of several key findings summarized in a new Statistical Brief (#124) from the Agency for Healthcare Research and Quality's (AHRQ's) Healthcare Cost and Utilization Project (HCUP). In Patient Characteristics of Opioid-Related Inpatient Stays and Emergency Department Visits Nationally and by State, 2014, AHRQ reports that the sharpest increase in hospitalization and emergency room treatment for opioids was among people ages 25 to 44. Between 2005 and 2014, the national rate of opioid-related inpatient stays increased more for females than for males. "Although the rate for males was higher in 2005, by 2014 the rate was the same for both sexes," the authors note. Identification of opioid-related stays and visits in this report is based on all-listed diagnoses and includes events associated with prescription opioids or illicit opioids such as heroin. The HCUP data is drawn from short-term, non-federal community hospital inpatient stays. Psychiatric and alcoholism/chemical dependency hospitals are excluded; however, if a patient received treatment for a psychiatric or chemical dependency condition in a community hospital, their data would be included in the nationwide sample.

11. **NEW "BEHAVIORAL HEALTH BAROMETER" PROVIDES A SNAPSHOT OF KEY NATIONAL DATA ON BEHAVIORAL HEALTH.** The latest edition of the *Behavioral Health Barometer, United States, Volume 4* has been released by the Substance Abuse and Mental Health Services Administration (SAMHSA). This report presents national data about the prevalence of behavioral health conditions. The data includes the rate of serious mental illness, suicidal thoughts, substance use, and underage drinking. The report also highlights the percentages of those who seek treatment for these conditions. The indicators included in the Barometer are measured through the National Survey on Drug Use and Health (NSDUH) and the National Survey of Substance Abuse Treatment Services (N-SSATS). "This analysis can help public health authorities and others determine

the best ways of meeting behavioral health care needs and disparities among various communities," said Acting Deputy Assistant Secretary Kana Enomoto.

12. **REPORT FOCUSES ON "ADVANCING BEST PRACTICES IN BEHAVIORAL HEALTH FOR ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER BOYS AND MEN."** A new strategy brief from the Substance Abuse and Mental Health Services Administration (SAMHSA) highlights essential approaches for addressing behavioral health disparities and providing effective services for Asian American, Native Hawaiian, and Pacific Islander (AANHPI) boys and men. The brief summarizes "best practices" and expert consensus on culturally appropriate approaches, treatment modalities, and effective tools in working with this population. This new report builds on a previous brief issued in March 2016, titled "A Snapshot of Behavioral Health Issues for Asian American/Native Hawaiian/Pacific Islander Boys and Men: An Overdue Conversation."

13. **REPORT: "A DAY IN THE LIFE OF OLDER ADULTS: SUBSTANCE USE FACTS."** "Substance use among older adults is a public health concern that could increase in the future, especially as the baby boom generation ages," notes a new report from the Substance Abuse and Mental Health Administration's (SAMHSA's) Center for Behavioral Health Statistics and Quality (CBHQ). The report uses three national datasets that "highlight the need to continue to monitor this aging population," particularly in some key areas of concern. For example, the report shows that, on an average day, 6 million older adults used alcohol and 132,000 older adults used marijuana. (Future analyses will look at the frequency of prescription drug misuse.) In addition, "alcohol use emerges as a source of concern," the report notes. Most substance use admissions for people aged 65 or older were primarily for alcohol.

14. **REDESIGNED LEARNING CENTER NOW AVAILABLE FOR NATIONAL REGISTRY OF EVIDENCE-BASED PROGRAMS AND PRACTICES.** The Substance Abuse and Mental Health Services Administration (SAMHS) has announced the launch of the new Learning Center for the National Registry of Evidence-Based Programs and Practices (NREPP). The website was designed to provide resources for developing, implementing, and sustaining culture-centered and evidence-based programs and practices. "Learning Center tools provide practical support for using evidence-based programs and practices to improve the behavioral health of clients, family members, and communities," SAMHSA noted. Learning Center resources are organized around five themes: 1) emerging evidence in culture-centered practices; 2) developing an evidence-based practice or program; 3) implementing a program; 4) sustaining a program; and 5) behavioral health topics.

15. **APA NATIONAL POLL FINDS AMERICANS SHOW STRONG SUPPORT FOR MENTAL HEALTH COVERAGE.** Seventy-seven percent (77%) of all Americans said private health insurance offered through an employer or union should cover mental health, including 76% of Democrats and 81% of Republicans. This is a key finding in an online national poll released by the American Psychiatric Association (APA). A majority (51%) of Americans said they feel that mental health should be covered by all types of insurance, including individually-purchased health insurance, by insurance purchased through the Health Care Exchange or Marketplace, Medicaid and Medicare, and other government provided sources (such as veteran's benefits). While about half of respondents said that they have somewhat or very adequate mental health insurance coverage, more than a quarter said they do not know about their mental health coverage. Accessing mental health care is challenging for many, with fewer than half of adults saying they know how to access mental health care if they need it. "This poll gives us some insight to American understanding of the importance of mental health and the strong bipartisan support for mental health coverage," said APA President Maria A. Oquendo, M.D., Ph.D. "However, the number of people who don't know how to access mental health care and don't know about their coverage raises concerns."

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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