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BEHAVIORAL HEALTH UPDATE: June 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. **CMS FINAL RULE UPDATING MANAGED MEDICAID/CHIP REGULATIONS INCLUDES A PROVISION GIVING MCOs FLEXIBILITY ON IMD EXCLUSION.** In in the May 6 *Federal Register,* the Centers for Medicare and Medicaid Services (CMS) published the long-anticipated final rule (CMS-2390-F) that updates – for the first time in more than a decade – Medicaid and Children's Health Insurance Program (CHIP) managed care regulations. The intent of CMS was to better align managed care regulations with existing commercial, Marketplace, and Medicare Advantage regulations. Among the many provisions included in the final rule is one that permits states flexibility to allow managed care enrollees aged 21 to 64 to access psychiatric services in inpatient psychiatric hospitals and crisis residential settings (undefined) for up to 15 days per month. Capitation payments can include projected utilization in IMDs, and the pricing of the capitation rate must be based on general hospital psychiatric units. The IMD provision is based on CMS authority that allows managed care plans to cover services or settings that are an alternative to those covered under the state plan, which are also known as 'in lieu of services." This is the first time that CMS in rulemaking (or in any

other official guidance) interpreted the "in lieu of service" authority to allow payments to IMDs. As outlined in a CMS summary of implementation dates, the IMD provision will be effective July 6 (that is, 60 days after the publication of the final rule). In addition, the final rule outlines new standards for managed care provider networks, quality measures, external quality review, and beneficiary rights and protections. In addition, the final rule imposes new requirements for medical loss ratios for managed care plans, implements best practices identified in existing managed long-term care services and support programs, and requires states to develop a Medicaid managed care quality rating system for health plans. Additional fact sheets describing all aspects of the final rule are online at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html. A CMS blog notes that "some 72 million Americans rely on Medicaid as their source of health insurance coverage this year." Almost two thirds of these Medicaid beneficiaries are enrolled in managed care, CMS told Congress when releasing the final rule.

2. **INTEGRATING BEHAVIORAL HEALTH INTO MEDICAID MANAGED CARE: DESIGN AND IMPLEMENTATION LESSONS FROM STATE INNOVATORS.** "Medicaid enrollees with behavioral health needs have a high prevalence of chronic conditions and are often frequent users of physical and behavioral health services," notes a new brief from the Center for Health Care Strategies, "yet many are served in fragmented systems of care with little to no coordination across providers. More and more states are pursuing managed care models that fully integrate behavioral and physical health services to enhance care coordination, improve outcomes, and control costs for this high-need population." *Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators* provides insights from Medicaid officials and health plan representatives in five states (Arizona, Florida, Kansas, New York, and Texas) that are integrating behavioral health services within a managed care arrangement. It explores three emerging options for integration (including comprehensive managed care carve-in, specialty plans for individuals with serious mental illness, and hybrid models) and outlines strategies for facilitating effective integrated care models. "A key takeaway from states profiled is the need to develop flexible integrated care approaches that leverage existing capacity and account for variations in managed care landscapes," the authors say. "Lessons from these five early innovators can inform other states pursuing similar initiatives."

3. **SUICIDE RATES UP 24% BETWEEN 1999 AND 2014, CDC REPORTS.** From 1999 through 2014, the age-adjusted suicide rate in the United States increased 24% (going from 10.5 to 13.0 per 100,000 population), according to a Data Brief report (No. 241) from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics. The pace of increase was greatest after 2006. Rates increased for males and females in all but the oldest age group. While men are three times more likely to commit suicide than women, the suicide rate for women increased 45% over the period compared with 16% for men, narrowing the gap. Men aged 75 and over had the highest suicide rate in 2014 at 38.8 per 100,000, although that is down 8% from 1999. The suicide rate for girls aged 10-14, while lowest overall, tripled over the period to 1.5 per 100,000. Women and men aged 45-64 also saw large increases, 63% and 43%, respectively. "Suicide is increasing against the backdrop of generally declining mortality," the CDC wrote, "and is currently one of the 10 leading causes of death overall and within each age group 10–64."

4. **NEW FAQs ON PARITY AND ACA OUTLINE INFORMATION HEALTH PLANS MUST DISCLOSE.** On April 20, the Departments of Health and Human Services (HHS), Labor (DOL), and Treasury issued an additional set of Frequently Asked Questions (FAQs) that include clarifications on the federal parity law (the *Mental Health Parity and Addiction Equity Act of 2008* or MHPAEA) and the *Affordable Care Act* (ACA), among other things. On parity (see Q8-Q11), the FAQs outline in detail, for example, the types of information that health plans must disclose to providers upon request (in Q9). In additional questions and answers, the April 20 FAQs also note that "group health plans and

issuers that offer [medication-assisted treatment] MAT benefits must do so in accordance with the requirements of MHPAEA and, accordingly, any financial requirements and treatment limitations may not be more restrictive than the predominant financial requirements and quantitative treatment limitations that apply to substantially all medical and surgical benefits in a classification. In addition, the special rule for multi-tiered prescription drug benefits also applies to the medication component of MAT." The new FAQs also provide clarifications regarding certain market reform provisions of the ACA, including emergency services protections, coverage of preventive services, prohibition on rescissions, coverage of individuals participating in approved clinical trials, and limitations on cost sharing under the ACA. All previously issued FAQs are also available at www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html.

5. **JOINT COMMISSION EATING DISORDERS STANDARDS BECOME EFFECTIVE JULY 1.** Effective July 1, The Joint Commission is implementing new behavioral healthcare standards "to better address the care, treatment or services of eating disorders programs." The new standards impact Joint Commission-accredited behavioral healthcare organizations providing outpatient or residential eating disorders programs. View a pre-publication version of the standards online or in the monthly Joint Commission *Perspectives*. According to a Joint Commission news release, the requirements will appear in the following chapters of the *Comprehensive Accreditation Manual for Behavioral Health Care Organizations*: Care, Treatment and Services; Leadership; Performance Improvement; and Rights and Responsibilities of the Individual. The requirements address several aspects of eating disorders programs, including assessments, data collection and analysis, transitions of care, roles of key staff and other clinicians, supervision of individuals served, family involvement, and more. In addition, the standards have a strong emphasis on several variables of eating disorders that need to be evaluated and treated, as well as the integration of medical and nutritional components.

6. **LETTER TO STATE MEDICAID OFFICIALS CLARIFIES CMS STANCE ON FEDERAL FINANCIAL PARTICIPATION FOR INCARCERATED INDIVIDUALS.** The Centers for Medicare and Medicaid Services' (CMS') Center for Medicaid and CHIP Services on April 28 issued a State Health Officials Letter (SHO#16-007) designed to facilitate successful re-entry for individuals transitioning from incarceration to their communities. According to a Health and Human Services (HHS) news release, the new guidance "updates decades-old policy and clarifies that individuals who are currently on probation, parole, or in home confinement are not considered inmates of a public institution. It also extends coverage to Medicaid-eligible individuals living in community halfway houses where they have freedom of movement, improving access to care for as many as 96,000 individuals in Medicaid expansion states over the course of the year." The guidance letter notes that "while the Medicaid statute limits payment for services for individuals while residing in correctional institutions, Medicaid coverage can be crucial to ensuring a successful transition following incarceration. Many individuals in the justice-involved population have a high prevalence of long-untreated, chronic healthcare conditions as well as a high incidence of substance use and mental health disorders." In an attached set of Q&As, CMS clarifies, among other things, rules about eligibility, maintenance of eligibility, and suspended eligibility status of Medicaid benefits for incarcerated persons.

7. **ARTICLE LOOKS AT MEDICARE COVERAGE OF SUBSTANCE ABUSE SERVICES.** A Medicare Learning Network (MLN) Matters® Special Edition article (SE1604) looks at "Medicare Coverage of Substance Abuse Services." The article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for substance abuse services provided to Medicare beneficiaries. "While there is no distinct Medicare benefit category for substance abuse treatment," notes the article, "such services are covered by Medicare when reasonable and necessary. The Centers for Medicare and Medicaid Services (CMS) provides a full range of services, including those services provided for substance abuse disorders." The article summarizes the

available services and provides reference links to other online Medicare information with further details about these services.

8. **2014 IPF QUALITY REPORTING DATA IS NOW PUBLIC.** Inpatient Psychiatric Facility Quality Reporting (IPFQR) data for the data-reporting period of 1/1/14 to 12/31/14 was posted for public viewing on May 4 to the Hospital Compare website at www.medicare.gov/hospitalcompare/psych-measures.html. IPFQR data is reported to the Centers for Medicare and Medicaid Services (CMS) each year in July/August and published the following April/May.

9. **RECORDING OF IPFQR WEBINAR ON PROPOSED QUALITY MEASURES IS NOW ONLINE.** A recording, slides, and a presentation transcript from a webinar (previously presented on May 5) for participants of the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program are now available. The "FY2017 Proposed Rule" webinar summarize the proposed major updates to the IPFQR Program quality measure requirements and the proposed non-measure changes, as outlined in a FY2017 proposed rule.

10. **RECORDING OF PEPPER WEBINAR IS ONLINE.** Slides, a recording, and review questions & answers from a May 4 TMF Health Quality Institute webinar titled "PEPPER [Program for Evaluating Payment Patterns Electronic Report] Update Webinar for Inpatient Psychiatric Facilities and Partial Hospitalization Programs" are now online at https://www.pepperresources.org/ under the IPF and PHP "Training and Resources" section. The PEPPER is a comparative data report that summarizes one provider's Medicare claims data statistics in areas that may be prone to or at risk for improper Medicare payments.

11. **MEDICARE LEARNING MATTERS ARTICLE CLARIFIES MEDICARE IPF CERTIFICATION AND RECERTIFICATION REQUIREMENTS.** On May 13, the Centers for Medicare and Medicaid Services (CMS) released a Medicare Learning Network Matters (MLNM) article titled **"**Clarification of Inpatient Psychiatric Facilities (IPF) Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification**"** *(MM9522).* The article contains a number of clarifications of the way Medicare Administrative Contractors (MACs) will handle physician certification, recertification, and delayed/lapsed certification and recertification. MACs are given the authority to use the overall information in the medical record (rather than specific language) to support the need for continued hospitalization, to honor delayed certification and recertification if there is a legitimate reason for the delay, and to reopen technical denial decisions related to certification. See the MM9522 article for a complete list of key points. The guidance restates that an IPF certification and recertification statement may only be signed by a physician.

12. **STUDY: HOSPITALIZATIONS FOR OPIOID ABUSE, RELATED INFECTIONS UP SHARPLY OVER DECADE.** Hospitalizations for opioid abuse/dependence increased 72% between 2002 and 2012 to an estimated 520,275 per year, while hospitalizations for opioid-associated infections rose 91% to 6,535, according to a study in *Health Affairs*. Intravenous administration of opioids and heroin can cause serious infections, such as endocarditis and septic arthritis, increasing hospitalization costs. "These findings have important implications for the hospitals and government agencies that disproportionately shoulder these costs and for clinicians, researchers and policymakers interested in estimating the potential impact of targeted public health interventions at the national level," the authors said.

13. **ASAM AND CIGNA TO COLLABORATE ON ADDICTION PERFORMANCE MEASURES. "**In response to the drug epidemic sweeping the country," Cigna announced a collaboration with the American Society of Addiction Medicine (ASAM) "to improve treatment for

people suffering from substance use disorders." Working with Brandeis University, ASAM said that it will use two years of Cigna claims data to test and validate ASAM performance measures related to medication prescribing for alcohol and opioid use disorders, and treatment after withdrawal management.

14. **PRESCRIBER TRAINING EYED AS ONE WAY TO ADDRESS OPIOID CRISIS.** In light of what the Centers for Disease Control and Prevention (CDC) has identified as an "epidemic of drug overdose deaths," prescriber training is gaining greater attention as one tool for addressing the problem. In May, an advisory panel to the Food and Drug Administration (FDA) recommended mandatory training for doctors who prescribe opioids. The training recommendation was one of several from the FDA advisory panel following a two-day hearing on the medical evidence regarding opioids and ways to improve their safety. The FDA is not required to follow the advice of its panelists, although it often does. In May, Sen. Richard Durbin (D-IL) sent letters to the American Medical Association, American College of Emergency Physicians, and others urging them to endorse evidence-based interventions and mandatory continuing medical education requirements for opioid prescribers. "When it comes to the opioid and heroin crisis, each stakeholder needs to do their part," wrote Sen. Durbin. In a May 11 blog published in the *Huffington Post* ("Confronting a Crisis: An Open Letter to America's Physicians on the Opioid Epidemic"), American Medical Association (AMA) President Steven Stack, M.D., called on American physicians to avoid initiating opioids for new patients with chronic non-cancer pain unless the benefits are expected to outweigh the risks. Among other actions, the practicing emergency physician also urged them to limit the amount of opioids prescribed for post-operative care and acutely-injured patients; register for and use their state Prescription Drug Monitoring Program; identify and help patients with opioid use disorder obtain evidence-based treatment; and co-prescribe naloxone to patients at risk for overdose. The AMA in its blog, however, did not call for mandatory training.

15. **INFORMATION BULLETIN ON MEDICAID SCREENING AND TREATMENT FOR MATERNAL DEPRESSION.** On May 11, the Center for Medicaid and CHIP Services issued an Informational Bulletin titled Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. The bulletin discusses the importance of early screening for maternal depression and clarifies the pivotal role Medicaid can play in identifying children with mothers who experience depression and its consequences. It also discusses connecting mothers and children to the help they need. "State Medicaid agencies may cover maternal depression screening as part of a well-child visit," the bulletin notes. "In addition, states must cover any medically necessary treatment for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit." Also see a CMS blog announcing release of the bulletin.

16. **REPORT EXAMINES THE RELATIONSHIP BETWEEN EXPOSURE TO A POTENTIALLY TRAUMATIC EVENT AND NEGATIVE HEALTH OUTCOMES IN ADULTHOOD.** Adults exposed to one or more potentially traumatic events (PTEs) in their lifetime were more likely to have health conditions such as mental illness, serious psychological distress, major depressive episodes, and suicidal thoughts in the past year than adults who had not been exposed to a PTE, according to a report from the Substance Abuse and Mental Health Services' (SAMHSA) Center for Behavioral Health Statistics and Quality (CBHSQ). People who had been exposed a PTE were also more likely to report that they had been diagnosed by their doctor as having asthma, high blood pressure, sinusitis, or ulcer, SAMHSA said. In addition, adults exposed to one or more lifetime PTEs were more likely to have used illicit drugs in the past year and their lifetime, have past month binge drinking and heavy drinking than among adults without exposure. The report used data from the 2008-2012 Mental Health Surveillance Study (MHSS), a nationally representative clinical follow-up study on a subsample of approximately 5,500 adults 18 or older, who responded to the annual National Survey on Drug Use and Health (NSDUH).

17. **STUDY: CHILDREN OF DEPRESSED PARENTS AT HIGH RISK OF ADVERSE CONSEQUENCES INTO ADULTHOOD.** Offspring of depressed parents have a higher risk for depression, morbidity, and mortality that persists into middle age, according to the latest report from a 30-year study of families at high- and low-risk for depression. The study was published online April 26 ahead of print in the *American Journal of Psychiatry*. "While adolescence is the major period of onset for major depression in both risk groups," the authors conclude, "it is the offspring with family history who go on to have recurrences and a poor outcome as they mature. In the era of personalized medicine, until a more biologically based understanding of individual risk is found, a simple family history assessment of major depression as part of clinical care can be a predictor of individuals at long-term risk." Also see a Columbia University Medical Center release detailing the findings.

18. **KAISER POLL LOOKS AT AMERICANS' ATTITUDES TOWARD SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES AND ACCESS.** A Kaiser Health Tracking Poll examines public opinion on the severity of health problems in the U.S., with a closer look at attitudes towards access to substance abuse treatment and mental health services. For example, a majority of Americans surveyed said that lack of access to care for people with substance abuse issues is a problem (75%), including 58% who said it is a major problem. Prescription drug addiction also impacts much of the public on a personal level, with 44% saying they personally know someone who has been addicted to prescription painkillers, including 20% who said the person was a family member and 2% who said they themselves were addicted. Most respondents said that strategies such as more pain management training for providers, expanded access to addiction treatment, and monitoring of doctors' prescribing of painkillers could be effective ways to address the epidemic. The vast majority of the public (87%) also said that the lack of access to care for people with mental health conditions is a problem, including almost three quarters (73%) who said it is a major problem. One in five Americans (21%) said that they or someone in their immediate family once needed mental health services but did not get the care. Those who did not get treatment cited several factors, including that they couldn't afford the cost (13% of the public overall); insurance wouldn't cover it (12%); they were afraid or embarrassed to seek care (10%); and they didn't know where to go to get care (8%). Also see a news release detailing survey participants' perspectives on state and federal policy initiatives.

19. **REPORT CALLS ON HHS TO REDUCE MENTAL HEALTH AND SUBSTANCE USE DISORDER STIGMA.** The National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine) has published a report that explores stigma and discrimination faced by individuals with mental or substance use disorders. "Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change" also recommends strategies for reducing stigma and encouraging people to seek treatment and other supportive services. Among other things, they suggest that the Department of Health and Human Services (HHS) "take lead responsibility among federal partners and key stakeholders in the design, implementation, and evaluation of multipronged, evidence-based national strategy to reduce stigma and to support people with mental and substance use disorders."

20. **CDC: FEWER ADULTS WITH SERIOUS PSYCHOLOGICAL DISTRESS UNINSURED THAN IN 2012.** About one in five working-age adults reporting serious psychological distress lacked health insurance when surveyed in the first nine months of 2015, down from 28% in 2012, according to a new report by the Centers for Disease Control and Prevention's National Center for Health Statistics. Among those with health insurance, 45% had public coverage and 38% had private coverage. About one-third of working-age adults with serious psychological distress (SPD) had seen or talked to a mental health professional in the past 12 months, down from 42% in 2012. About one-quarter of those with serious psychological distress reported forgoing medical care due to cost, down from one-third in 2012. *Access to Care Among Adults Aged 18–64 With Serious Psychological Distress: Early Release of Estimates from the National Health Interview Survey, 2012–September 2015* provides estimates of

healthcare access and utilization for adults with (and without) SPD in the past 30 days, which the CDC says is "an indicator of mental health problems severe enough to cause moderate-to-serious impairment in social, occupational, or school functioning and to require treatment."

21. **SURVEY PROVIDES STATE-BY-STATE DETAIL ON LEGAL ISSUES RELATED TO DELIVERY OF BEHAVIORAL HEALTH TELEMEDICINE.** A new comprehensive 50-State Survey of Telemental/Telebehavioral Health (2016) details the laws, regulations, and regulatory policies impacting telemental health in all 50 states and the District of Columbia. Compiled by attorneys in Epstein Becker Green's Telehealth practice, the survey details the rapid growth of telemental health (defined as mental health care delivered via interactive audio or video, computer programs, or mobile applications) and the increasingly complex legal issues associated with this trend. The survey also provides one source for state-by-state coverage of legal issues such as definitions of "telehealth" or "telemedicine"; licensure requirements; governing bodies; reimbursement and coverage issues; the establishment of the provider-patient relationship; provider prescribing authority; and accepted modalities for delivery (e.g., telephone, video) to meet standards of care.

22. **OCR CLARIFIES HIPAA RULES INVOLVING MEDIA.** The Health and Human Services (HHS) Office of Civil Rights (OCR) has posted a response to a frequently asked question on the application of the *Health Information Portability and Accountability* (HIPAA) privacy rules in situations involving media access to protected health information (PHI). OCR notes that, in general, healthcare providers "cannot invite or allow media personnel, including film crews, into treatment or other areas of their facilities where patients' PHI will be accessible in written, electronic, oral, or other visual or audio form, or otherwise make PHI accessible to the media, without prior written authorization from each individual who is or will be in the area or whose PHI otherwise will be accessible to the media."

23. **APA PRACTICE GUIDELINE FOCUSES ON THE USE OF ANTIPSYCHOTICS TO TREAT AGITATION OR PSYCHOSIS IN PATIENTS WITH DEMENTIA.** Published in the May 2016 *American Journal of Psychiatry* is the American Psychiatric Association's (APA) Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia. The guideline is intended to apply to individuals with dementia in all settings of care as well as to care delivered by generalist and specialist clinicians. Recommendations regarding treatment with antipsychotic medications are not intended to apply to individuals who are receiving antipsychotic medication for another indication (e.g., chronic psychotic illness) or individuals who are receiving an antipsychotic medication in an urgent context.

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