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BEHAVIORAL HEALTH UPDATE: December 2015  
A Monthly Report for Members  
of the American Hospital Association [www.aha.org](http://www.aha.org) and the  
National Association of Psychiatric Health Systems, [www.naphs.org](http://www.naphs.org)

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1. Final CY16 hospital OPPS rule includes partial hospitalization rates.
2. Congress passes Medicaid Emergency Psychiatric Demonstration legislation, which will move to president for signature.
3. *Protecting Our Infants Act* signed into law.
4. Joint Commission annual report looks at hospital quality and top performers.
5. Links to Joint Commission's 2016 National Patient Safety Goals for both hospitals and for behavioral health care are now online.
6. Joint Commission posts sentinel event data.
7. Policy brief examines parity-law enforcement.
8. Parity Implementation Coalition applauds two parity developments.
9. Reports track states' progress on parity.
10. CMS discusses feedback received on collaborative care models.
11. Four SAMHSA staff changes announced.
12. Survey: 10% of adults have a drug use disorder at some point in their lives, but 75% report not receiving any form of treatment.
13. Heroin and painkiller abuse are key concerns in DEA's 2015 drug threat assessment.
14. Report looks at prescribing practices for substance use disorders in physician office settings; pocket guide on medications available.
15. December 19 is deadline to nominate a White House "Champion of Change" for advancing prevention, treatment, and recovery.
16. Adults with schizophrenia at risk of cardiovascular death, study finds.
17. Drug-related suicide attempts by middle-aged adults likely to involve alcohol combined with drugs, SAMHSA reports.
18. Tricare publishes FY16 mental health rate updates.
19. December 14 is deadline to participate in a NAMI survey measuring access to mental health/substance use care.

**1. FINAL CY16 HOSPITAL OPPS RULE INCLUDES PARTIAL HOSPITALIZATION RATES.** A [final rule](#) detailing both the CY2016 partial hospitalization rates under the hospital outpatient prospective payment system (OPPS) has been released by the Centers for Medicare and Medicaid Services (CMS). The final rule will be published in the November 13 *Federal Register*. The final adjusted rates are as follows. The hospital-based Level 1 (3 services) rate is \$183.41. The hospital-based Level II (4 or more services) rate is \$212.67. The community mental health center (CMHC) Level 1 (3 services) rate is \$94.49. The CMHC Level 2 (4 or more services) rate is \$143.00. Appendices and other details are available [online](#).

**2. CONGRESS PASSES MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION LEGISLATION, WHICH WILL MOVE TO PRESIDENT FOR SIGNATURE.** In November both chambers of Congress passed (and will soon send to the President for signature) legislation to extend and expand the Medicaid Emergency Psychiatric Demonstration. The *Improving Access to Emergency Psychiatric Care Act of 2015*, S.599, would extend the Medicaid Emergency Psychiatric Demonstration Program through September 2016, as long as it does not increase Medicaid spending, and expand the program to public facilities. The program allows eligible states to pay certain institutions for mental disease for emergency psychiatric care provided to Medicaid enrollees aged 21

to 64. The bill also allows the Department of Health and Human Services to extend the program for three more years and to more states, subject to the same budget-neutrality standard, and requires HHS to recommend by April 2019 whether to make the program permanent. The legislation, which has been supported by both AHA and NAPHS, next goes to the President for signature.

**3. PROTECTING OUR INFANTS ACT SIGNED INTO LAW.** On November 25, President Barack Obama signed into law the *Protecting Our Infants Act* (S.799/H.R.1462). The law directs the Health and Human Services (HHS) Secretary to develop recommendations for preventing and treating prenatal opioid use and for treating infants born dependent on opioids. It also encourages the Centers for Disease Control and Prevention (CDC) to work with states to help them improve their public health response to the epidemic. Researchers estimate that more than one opioid-dependent infant is born every hour.

**4. JOINT COMMISSION ANNUAL REPORT LOOKS AT HOSPITAL QUALITY AND TOP PERFORMERS.** The Joint Commission has released its latest annual quality report titled [America's Hospitals: Improving Quality and Safety – The Joint Commission's Annual Report 2015](#). The report summarizes the performance of Joint Commission-accredited hospitals on accountability measures of evidence-based care processes closely linked to positive patient outcomes, including the Hospital-Based Inpatient Psychiatric Services (HBIPS) measures (see pages 17-19) and substance use measures (page 22). The 2015 report also includes Top Performer hospitals, which now represent 31.5% of all Joint Commission-accredited hospitals reporting accountability data. A [news release](#) is online.

**5. LINKS TO JOINT COMMISSION'S 2016 NATIONAL PATIENT SAFETY GOALS FOR BOTH HOSPITALS AND FOR BEHAVIORAL HEALTH CARE ARE NOW ONLINE.** The Joint Commission has posted a [webpage](#) with links to the new 2016 National Patient Safety Goals (NPSGs). Included on each program's page is the chapter and an easy-to-read version of the NPSGs. Scroll down to view the [hospital NPSGs](#) and the [behavioral health NPSGs](#), which are effective January 1, 2016. For frequently asked questions (FAQs) about the NPSGs, visit the [Standards FAQs section](#).

**6. JOINT COMMISSION POSTS SENTINEL EVENT DATA.** The Joint Commission has posted four separate analyses of sentinel events. These include 1) a [Sentinel Event Data Summary](#) detailing Sentinel Events reviewed by The Joint Commission (as of 10/26/2015); 2) [Sentinel Event Data - Root Causes by Event Type](#) for 2004-3<sup>rd</sup> Quarter 2015; 3) [Sentinel Event Data - General Information](#) for 1995-3<sup>rd</sup> Quarter 2015; and 4) [Sentinel Event Data - Event Type by Year](#) for 1995-3<sup>rd</sup> Quarter 2015. “This sentinel event-related data, reported to The Joint Commission from our accredited organizations, demonstrates the need of The Joint Commission and accredited healthcare organizations to continue to address these serious adverse events. This data also supports the importance of establishing National Patient Safety Goals and focusing our energies on addressing serious errors within healthcare organizations.

**7. POLICY BRIEF EXAMINES PARITY-LAW ENFORCEMENT.** A new [Health Policy Brief](#) looks at the issue of enforcing mental health parity five years after the *Mental Health Parity and Addiction Equity Act* (MHPAEA) took effect. The brief was jointly produced by *Health Affairs* and the Robert Wood Johnson Foundation as an update to an [April 3, 2014, policy brief](#) that examined changes in mental health parity brought about by the implementation of the *Affordable Care Act* (ACA). The new brief notes that over the past decade, Congress has enacted several laws that today mean that “nearly all insured Americans are now entitled to receive their mental health and substance use benefits at the same level as their benefits for other medical care.” The brief concludes that “enforcing those rights, however, has not been consistent, and many patients are left to fend for themselves.” The brief notes that it is likely that there will be more cases going to court to enforce patients' rights under the MHPAEA.

## **8. PARITY IMPLEMENTATION COALITION APPLAUDS TWO PARITY**

**DEVELOPMENTS.** Two recent actions “provide important new tools to assist plan participants with receiving addiction and mental health benefits as guaranteed under the [federal] parity law,” according to the Parity Implementation Coalition (PIC). The first development, according to a PIC [news release](#), is a recent U.S. Supreme Court ruling. On November 16, the Supreme Court announced it will not review the decision of the Court of Appeals for the 2<sup>nd</sup> Circuit in New York ([UnitedHealth Group, Inc., et al, v. Jonathan Denbo, et al](#)) that found that individuals can sue the entity that manages their care directly rather than their employers or plan sponsors. The Second Circuit Court of Appeals found that when a claims administrator has total control over benefits claims and makes “final and binding” decisions on appeals of denials, the claims administrator is an appropriate defendant. The Supreme Court’s decision not to review the case means that ruling stands and the case may proceed, “which is an important victory for patients as it allows them to seek legal recourse against the plan that makes behavioral health benefit determinations,” said the PIC. The second positive development, the PIC said, is release of recent [guidance](#) on the *Mental Health Parity and Addiction Equity Act* by the Departments of Labor, Health and Human Services, and Treasury. The guidance 1) underscores that plans must make medical necessity criteria available to current and potential plan participants, 2) reiterates that plans must disclose this criteria regardless of whether that criteria is proprietary or of commercial value, and 3) requires ERISA plans to provide the instruments under which the plan is established or operated to plan participants within 30 days of the request.

**9. REPORTS TRACK STATES’ PROGRESS ON PARITY.** “[ParityTrack](#),” a partnership between The Kennedy Forum and the Scattergood Foundation, has issued an evaluation of parity implementation in all 50 states, including reports on the pertinent legislation, regulations, and litigation in each state. It also offers a report on [federal activity](#).

**10. CMS DISCUSSES FEEDBACK RECEIVED ON “COLLABORATIVE CARE MODELS.”** In the [final rule](#) detailing the CY2016 Medicare physician fee schedule, the Centers for Medicare and Medicaid Services (CMS) responded to feedback submitted to the agency’s call for comments on the future potential of payment for the “Collaborative Care Models for Beneficiaries with Common Behavioral Conditions.” In the final rule, CMS said “We received many positive comments regarding the possibility of implementing new payment codes that would allow more accurate reporting and payment when these services are furnished to Medicare beneficiaries. We appreciate commenters’ interest in appropriate coding and payment for these services. We will take all comments into consideration as we consider the development of proposals in future rulemaking.”

**11. FOUR SAMHSA STAFF CHANGES ANNOUNCED.** Four personnel changes have been [announced](#) by the Substance Abuse and Mental Health Services Administration (SAMHSA). First, Rear Admiral Peter Delany will move from the Center for Behavioral Health Statistics and Quality (CBHSQ) to serve on a detail assignment as a Special Advisor to the director of the Office of National Drug Control Policy. There he will focus on data and analytic policy issues in support of the President’s Initiative to Combat Opiate Use. Second, Daryl Kade, who has led the Center for Substance Abuse Treatment (CSAT) for the past year, will serve as CBHSQ’s acting director. Third, Tom Hill has been appointed SAMHSA’s Senior Advisor for Addiction and Recovery and will serve as CSAT’s acting director. Fourth, starting December 13 [Amy Haseltine](#) will serve as SAMHSA’s acting principal deputy administrator.

**12. SURVEY: 10% OF ADULTS HAVE A DRUG USE DISORDER AT SOME POINT IN THEIR LIVES, BUT 75% REPORT NOT RECEIVING ANY FORM OF TREATMENT.** A survey of American adults revealed that drug use disorder is common, co-occurs with a range of mental health disorders, and often goes untreated. The [study](#), funded by the National Institute on Alcohol

Abuse and Alcoholism (NIAAA), found that about 4% of Americans met the criteria for drug use disorder in the past year and about 10% have had drug use disorder at some time in their lives. The study was released online November 18 in the *Journal of the American Medical Association (JAMA) Psychiatry*. “Based on these findings, more than 23 million adults in the United States have struggled with problematic drug use,” [said](#) NIAAA Director George F. Koob, Ph.D. “Given these numbers, and other recent findings about the prevalence and under-treatment of alcohol use disorder in the U.S., it is vitally important that we continue our efforts to understand the underlying causes of drug and alcohol addiction, their relationship to other psychiatric conditions and the most effective forms of treatment.”

**13. HEROIN AND PAINKILLER ABUSE ARE KEY CONCERNS IN DEA’S 2015 DRUG THREAT ASSESSMENT.** The Drug Enforcement Administration (DEA) recently released the [2015 National Drug Threat Assessment](#) (NDTA), which found that drug overdose deaths are the leading cause of injury death in the United States, ahead of deaths from motor vehicle accidents and firearms. The report also notes that heroin availability is up across the country, as are abusers, overdoses, and overdose deaths. Since 2002, prescription drug deaths have outpaced those of cocaine and heroin combined. Abuse of controlled prescription drugs is higher than that of cocaine, methamphetamine, heroin, MDMA, and PCP combined. "Sadly this report confirms what we've known for some time: drug abuse is ending too many lives too soon and destroying families and communities," said DEA Acting Administrator Chuck Rosenberg. “We must reach young people at an even earlier age and teach them about its many dangers and horrors.”

**14. REPORT LOOKS AT PRESCRIBING PRACTICES FOR SUBSTANCE USE DISORDERS IN PHYSICIAN OFFICE SETTINGS; POCKET GUIDE ON MEDICATIONS AVAILABLE.** Approximately 3.4 million visits to physicians' offices in 2010 involved prescriptions for treating substance use disorders, according to a short report from the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Behavioral Health Statistics and Quality (CBHSQ). See the [CBHSQ Report: Medication Prescribing and Behavioral Treatment for Substance Use Disorders in Physician Office Settings](#). SAMHSA has also released a pocket guide that provides guidance for the use of medication-assisted treatment for alcoholism and alcohol abuse in clinical practice. Download the [Medication for the Treatment of Alcohol Use Disorder: Pocket Guide](#).

**15. DECEMBER 19 IS DEADLINE TO NOMINATE A WHITE HOUSE “CHAMPION OF CHANGE” FOR ADVANCING PREVENTION, TREATMENT, AND RECOVERY.** The White House is [seeking nominations](#) of “outstanding individuals” who are working to address the prescription drug abuse and heroin epidemic. In spring 2016, the White House will honor “Champions of Change” for their contributions. Complete an [online nomination form](#) (at the bottom of the webpage) no later December 19.

**16. ADULTS WITH SCHIZOPHRENIA AT RISK OF CARDIOVASCULAR DEATH, STUDY FINDS.** Adults with schizophrenia are 3.5 times as likely to die prematurely as adults in the general population, according to a study published online October 28 in *JAMA Psychiatry*. Cardiovascular and respiratory diseases were found to be the chief causes of mortality for adults with schizophrenia, with tobacco use identified as a modifiable risk factor, according to the study, which was partially funded by the Agency for Healthcare Research and Quality (AHRQ). In [“Premature Mortality Among Adults With Schizophrenia in the United States,”](#) researchers examined records of more than 1.1 million Medicaid patients with schizophrenia nationwide, looking at the cause of death for the 74,003 who died. Of the 65,553 deaths with a known cause, 9,812 were due to unnatural causes, including suicide, homicide, accidents and substance abuse. The remaining 55,741 deaths were due to natural causes, primarily cardiovascular disease, lung cancer, chronic obstructive pulmonary disease and influenza and pneumonia. The authors concluded that aggressive identification of cardiovascular risk factors and

steps to reduce tobacco use and substance abuse should be among the highest priorities for treating adults with schizophrenia.

**17. DRUG-RELATED SUICIDE ATTEMPTS BY MIDDLE-AGED ADULTS LIKELY TO INVOLVE ALCOHOL COMBINED WITH DRUGS, SAMHSA REPORTS.** In 2013, an estimated 1.3 million adults aged 18 or older (0.6% of the population) attempted suicide in the past year, 2.7 million (1.1%) made suicide plans, and 9.3 million (3.9%) had serious thoughts of suicide, according to a [short report](#) from the Substance Abuse and Mental Health Services Administration (SAMHSA). The rate of death by suicide for middle-aged adults (aged 35 to 64) increased by 28.4% from 1999 to 2010. The report notes that the Drug Abuse Warning Network (DAWN) estimates 228,366 emergency department (ED) visits were for drug-related suicide attempts in 2011. Of these, middle-aged patients aged 35 to 64 accounted for 99,559 of these visits. About 39% (38,616 visits) of ED visits for drug-related suicide attempts by middle-aged patients involved alcohol combined with other drugs. In contrast, only 24% of other drug-related ED visits (excluding adverse reactions) by middle-aged patients involved alcohol combined with other drugs. “Although substance abuse problems are not always present in patients who visit the ED for drug-related suicide attempts, alcohol and drug use are commonly associated with suicidal behavior,” the report says. “People who are seriously considering suicide may have a lower risk of suicide attempts after they stop using drugs and alcohol, compared with those who are suicidal and are still using drugs or alcohol. Therefore, families, friends, clinicians, and suicide prevention programs should consider encouraging those at risk for suicide to abstain from using alcohol and drugs.”

**18. TRICARE PUBLISHES FY16 MENTAL HEALTH RATE UPDATES.** The Department of Defense has published a [notice](#) of TRICARE fiscal year 2016 (FY16) mental health rate updates. The notice provides the updated regional per-diem rates for low-volume mental health providers; the update factor for hospital-specific per-diems; the updated cap per-diem for high-volume providers; the beneficiary per-diem cost-share amount for low-volume providers; and, the updated per-diem rates for both full-day and half-day TRICARE partial hospitalization programs for FY16. The rates are effective for services on or after October 1, 2015.

**19. DECEMBER 14 IS DEADLINE TO PARTICIPATE IN A NAMI SURVEY MEASURING ACCESS TO MENTAL HEALTH/SUBSTANCE USE CARE.** The National Alliance on Mental Illness (NAMI) is conducting an online [Coverage4Care survey](#) to measure access to mental health and substance use care in the era of the *Affordable Care Act*. “By collecting responses from across the country, we hope to gain a sense of what is helping people and what difficulties still exist,” NAMI says. The 20-minute survey is open to individuals and families, regardless of whether or not they have health insurance. Respondents may complete the survey on their own or on behalf of a loved one. Contact Sita Diehl at [sdiehl@nami.org](mailto:sdiehl@nami.org) with questions.

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