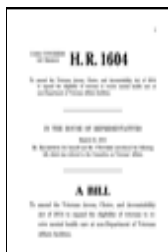


To: Members, AHA's Section for Psychiatric & Substance Abuse Services
From: Rebecca Chickey, Director, Section for Psychiatric & Substance Abuse Services
Subject: **Update on Key Issues in the Behavioral Health Care Field:** [August 2015](#)

AHA Advocacy Update

Bill on Newborn Opioid Dependency Clears Committee: The House Energy and Commerce Committee recently approved the AHA-supported Protecting Our Infants Act ([H.R. 1462](#)). The bipartisan legislation, authored by Rep. Katherine Clark (D-MA), would direct the Secretary of Health and Human Services (HHS) to develop a strategy and recommendations to decrease the number of infants with opioid dependency, and it would encourage the Centers for Disease Control and Prevention to work with states to improve the public health response to this epidemic. Senate Majority Leader Mitch McConnell (R-KY) introduced the companion bill (S. 799), which has been referred to the Senate Health Education Labor & Pensions (HELP) Committee.



AHA Supports Veterans' Mental Health Care Access Act: [H.R. 1604](#) would amend the Veterans Access, Choice and Accountability Act to include access to non-VA mental health services, regardless of whether the veteran has attempted to schedule an appointment at a VA facility or the location of the veteran's residence. AHA Senior Vice President Tom Nickels wrote to the bill's author, Rep. Tom MacArthur (R-NJ), "We believe your legislation will address some of the barriers veterans may face when trying to receive mental health services. This is incredibly important in light of the devastating statistics on veterans' mental health problems, including suicides, post-traumatic stress disorder, and other service-related mental health disorders."

Congress Ramping Up for Mental Health Focus this Fall: On July 29, HELP Committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) introduced S. 1893, the [Mental Health Awareness and Improvement Act](#). The measure, with 19 bipartisan cosponsors, would reauthorize and improve several HHS programs designed to improve awareness, prevention and early identification of mental health disorders, including suicide prevention, and it would boost Federal efforts to help states and local communities meet their residents' mental health needs. The Alexander-Murray bill emerged as two of its original cosponsors, Sens. Bill Cassidy (R-LA) and Chris Murphy (D-CT) introduced the *Mental Health Reform Act* on August 4. According to the sponsors, the bipartisan legislation would create an assistant secretary within HHS to coordinate federal mental health services, a committee to coordinate research and treatment for serious mental illness, and a national policy laboratory to provide innovation grants. The bill also would require the Departments of Labor, HHS and Treasury to conduct audits and issue guidance on mental health parity implementation, and provide grants to help states integrate physical and mental health care and provide early intervention for children at risk for mental illness. In addition, the legislation would allow Medicare and Medicaid patients to use mental health and primary care services at the same location and on the same day, and repeal the Medicaid exclusion on inpatient treatment for adults aged 22-64 in Institutions for Mental Disease if the Centers for Medicare & Medicaid Services (CMS) actuary certifies that the provision would not lead to a net increase in federal spending. In many ways it is similar to [HR 2646](#), introduced by Reps.

Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX), in June. The House Energy and Commerce Committee, which has jurisdiction over the Murphy-Johnson bill has signaled that it will tackle mental health legislation when Congress returns from its August recess. Committee Chairman Fred Upton and leading Democrat Frank Pallone and are comparing the effort to the 21st Century Cures Act, which passed the House with significant bipartisan support.

AHA Regulatory Update



Inpatient Psychiatric Facility PPS Final Rule: CMS has issued its [inpatient psychiatric facility final rule](#) for fiscal year 2016. The rule will increase IPF Prospective Payment System (PPS) rates by 1.5% in FY 2016, after accounting for inflation and other adjustments. Specifically, the final rule includes an initial market-basket update of 2.4% for those hospitals that submit data on quality measures; hospitals not submitting data will receive a 0.4% update. Beginning in 2016, CMS will replace the Rehabilitation, Psychiatric and Long-Term Care market basket with a new, IPF-specific market basket based on data from both freestanding and hospital-based IPFs. In addition, CMS will change the IPF quality measure set by adding five new measures and removing three. The agency also will change some data reporting requirements, such as requiring IPFs to report measure data as a single, yearly count instead of by quarter and patient age. The final rule will take effect Oct. 1. AHA staff is reviewing the rule and members will receive a Special Bulletin soon with further details.


Final Inpatient PPS Rule: CMS recent issued its hospital [inpatient prospective payment system final rule](#) for fiscal year 2016, which will increase rates by 0.9% after accounting for inflation and other adjustments. This will impact reimbursement for Medicare patients treated in general hospital psychiatric programs that are not classified by Medicare as distinct-part units. The rule also includes ACA-mandated Medicare Disproportionate Share Hospital reductions, which will reduce overall Medicare DSH payments by \$1.2 billion in FY 2016. Furthermore, CMS did not extend the partial enforcement delay of the two-midnight policy that expires on Sept. 30, despite proposing changes to the policy in the outpatient PPS rule that would not take effect before Jan. 1, 2016. Ashley Thompson, AHA vice president and deputy director, Policy, [said](#) hospitals were “dismayed” by the lack of a delay. Most of the provisions in the final rule will take effect Oct. 1. AHA staff is reviewing the rule and members will receive a Special Bulletin soon with further details.

AHA Gives IRS Evidence to Include Housing as Community Benefit: The AHA, Catholic Health Association of the United States and Association of American Medical Colleges [responded](#) to an Internal Revenue Service request for specific research supporting the inclusion of housing as a community benefit activity on Part I of Schedule H. “These resources strongly support our position that housing, an essential component of the infrastructure needed to promote and sustain good health, should be counted as a Community Benefit activity in Part I when undertaken by tax-exempt hospitals,” the groups wrote.

Physician Fee Schedule (PFS) Proposed Rule: In the July 15 *Federal Register*, CMS published a [proposed rule](#) for the 2016 physician fee schedule, which sets the policies and payments for physician visits under Medicare fee-for-service (Part B). Within that proposed rule, CMS is seeking comment on the potential expansion of the Comprehensive Primary Care Initiative, a CMS Innovation Center initiative designed to improve the coordination of care for Medicare beneficiaries; this includes “Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions.” An AHA [Regulatory Advisory](#), [CMS release](#) and [fact sheet](#) provide details on the overall proposed rule. Comments are due September 8.

Proposed Standards for Behavioral Health: Two sets of Joint Commission Behavioral Health Manual standards have been released for field review. One set addresses behavioral health care standards for [permanent housing support services](#). The other set addresses [eating disorders](#). Comments are due August 17.

AHA Resources

	<p>Reducing Readmissions through Patient Support</p> <p>Recent research suggests that nearly 60 percent of variation in readmission rates is due to community-level factors. In response, hospitals are launching intensive programs designed to help high-risk patients to navigate the physical, social and behavioral barriers to health.</p>	<p>Three Ways Hospitals Are Improving Behavioral Health Care</p> <p>Hospitals are confronting the lack of mental health services head on by integrating treatment into primary care, developing partnerships with other organizations and supporting vulnerable families.</p>	<p>Connecting Patients to Outpatient Services</p> <p>Florida's Lee Memorial Health System reduces emergency department overuse for behavioral health issues by providing shelter to homeless patients and forming supportive relationships with others.</p>
---	--	---	---

Collaborative Efforts to Improve Health: Five hospital-led partnerships to improve community health received the 2015 AHA [NOVA Awards](#) at the [Health Forum/AHA Leadership Summit](#) in San Francisco. One of the winning programs, the [Mayor's Healthy City Initiative](#), includes more than 70 partner organizations from local government, community organizations, faith-based groups, schools, businesses and health care providers, including the area's four acute care hospitals. A community needs assessment conducted jointly by the initiative's partner organizations highlighted the need to focus on obesity, HIV and AIDS, mental and behavioral health and emergency department overuse. Specific efforts have included school-based and community education; education and public policy advances; patient navigation programs; and transportation programs.

Join an Online Community Dedicated to Improve Care Transitions: AHA's Health Research & Educational Trust (HRET) has been awarded a grant from the Gordon and Betty Moore Foundation to strengthen care transitions. The purpose of the project, "*Huddle for Care*," is to create an online community designed to foster sharing and learning among individuals in the care transitions field. The project seeks to accelerate the spread of ideas across the country by creating an online forum in which those involved with transitional care programs can share effective strategies to overcome the main challenges associated with providing high-quality care transitions, including transition challenges faced by providers of behavioral health services. Visit the [HRET website](#) to learn more.

AHA Constituency Section Resources

If you missed the recent webcast: *Community-based Behavioral Health Solutions – Spartanburg Regional Healthcare System* held last month, the recording and power point are now available at: <http://www.aha.org/hospital-members/advocacy-issues/mentalhealth/150707call.shtml>

The [August Behavioral Health Update](#) includes, among other items, [AHA](#) and [NAPHS](#) comments on the Medicaid/CHIP Managed Care [proposed rule](#) – modifying the IMD exclusion; HHS [announced](#) funding to help states treat substance use disorders; CMS [announced](#) Section 1115 demonstration projects to support a full continuum of services for Medicaid enrollees with substance use disorders; and the hospital Outpatient PPS [proposed rule](#), which includes CY16 partial hospitalization rates and planned changes to the [two-midnight](#) policy.

For additional resources, such as the U.S. Preventive Services Task Force [recommendation](#) to screen all adults for depression in a primary care setting; an Alliance for Health Reform toolkit titled [Telemedicine: The Promise and Challenges](#); a new report, titled [Characteristics of Hospital Stays for Super-utilizers by Payer, 2012](#), showing that behavioral health disorders were among the top 10 principal diagnoses for “super-utilizers”; a new [framework](#) for bringing evidence-based psychosocial interventions into clinical practice to improve outcomes; a [SAMHSA report](#) showing gaps in treatment among racial/ethnic minority populations; and a new [report](#) from the Agency for Healthcare Research and Quality showing that one-third of adult hospital stays involve mental/substance use disorders, go to the Section’s website at www.aha.org/psych.

Rebecca B. Chickey

Director, Section for Psychiatric & Substance Abuse Services, 615-354-0507; rchickey@aha.org