Legal Divisions Joint Meeting
March 29, 2016
Washington Update

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Very congenial markup in Committee March 16 of S. 2680.

Committee members, Chairman Lamar Alexander (R-TN), credited Senators Chris Murphy (D-CT) and Bill Cassidy (R-LA) for consensus.

Committee approved bill, with four substance use treatment-oriented bills unanimously, by voice vote:

- Sen. Edward Markey’s (D-MA) S. 1455, Recovery Enhancement for Addiction Treatment Act (Treat Act), (increases from 30 to 100 the number of patients to which a practitioner can dispense narcotic drugs for maintenance or withdrawal);

- Sen. Tim Kaine’s (D-VA) S. 2256, Co-Prescribing Saves Lives Act of 2015 (training and co-prescribing guidelines for naloxone);

- Sen. Jeanne Shaheen’s (D-NH) S. 480, National All Schedules Prescription Electronic Reporting (provides state-administered drug monitoring programs access to prescription history); and

- Sen. Bob Casey’s (D-PA) S. 2687, Plan of Safe Care Improvement Act (improves plans of safe care for infants born with substance addiction or fetal alcohol syndrome).
HELP Committee Markup of Mental Health Reform Act of 2016 (cont’d)

- Approved bill includes as-yet-unseen Committee amendments to strengthen parity compliance and enforcement.
- Following vote, Committee members talked about amendments they intend to offer on the floor, including:
  - an IMD exclusion exception amendment to be offered by Senator Susan Collins (R-ME);
  - an amendment creating EHR incentive payments for behavioral health providers, to be offered by Senator Whitehouse (D-RI); and
  - a second Whitehouse amendment to make child psychiatrists eligible for the National Health Service Corps;
- Will also be a floor amendment from Sen. Blount (R-MO) to expand the § 223 Demo to the 24 states that have won planning grants.
- Chairman Alexander hopes to have bill on Senate floor by 2d week of April with the Senate HELP version of 21st Century Cures.
  - Timing in the hands of Majority Leader Mitch McConnell (R-KY).
HELP Committee Markup of Mental Health Reform Act of 2016 (cont’d)

- 163-page second draft does not do much that wasn’t already in existence, formally or formally.
- Differences between 1st Discussion Draft and 2d Discussion Draft (new):
  - **Sec. 204.** Substance use disorder treatment needs of regional and national significance.
  - **Sec. 205.** Priority substance use disorder prevention needs of regional and national significance.
  - **Sec. 304.** Study of distribution of funds under the substance use disorder prevention and treatment block grant and the community mental health services block grant.
  - **Sec. 305.** Helping States and local communities address emerging drug issues.
  - **Sec. 407.** Reauthorizing mental and behavioral health education and training grants.
  - **Sec. 408.** Information and awareness on eating disorders.
  - **Sec. 409.** Education and training on eating disorders.
  - **Sec. 410.** Strengthening community crisis response systems.
HELP Committee Markup of Mental Health Reform Act of 2016 (cont’d)

- More differences between 1st Discussion Draft and 2d Discussion Draft (new):
  - **Sec. 505.** Screening and treatment for maternal depression.
  - **Sec. 506.** Infant and early childhood prevention, intervention and treatment.
  - **TITLE VII—MENTAL HEALTH AWARENESS AND IMPROVEMENT**
    - **Sec. 702.** Garrett Lee Smith Memorial Act reauthorization.
    - **Sec. 703.** Mental health awareness training grants.
    - **Sec. 704.** Children’s recovery from trauma.
    - **Sec. 705.** Assessing barriers to behavioral health integration.
    - **Sec. 706.** Increasing education and awareness of treatments for opioid use disorders.
    - **Sec. 707.** Examining mental health care for children.
    - **Sec. 708.** Evidence-based practices for older adults.
    - **Sec. 709.** National violent death reporting system.
    - **Sec. 710.** GAO study on Virginia Tech recommendations.
    - **Sec. 711.** Performance metrics.
HELP Committee Markup of Mental Health Reform Act of 2016 (cont’d)

More differences between 1st Discussion Draft and 2nd Discussion Draft (new):

- **TITLE VIII—PREVENTION AND TREATMENT OF OPIOID USE DISORDER**
  - **Sec. 801.** FDA opioid action plan.
  - **Sec. 802.** Disclosure of information to State controlled substance monitoring programs.
  - **Sec. 803.** GAO report on State prescription drug monitoring programs.
  - **Sec. 804.** NIH opioid research.
  - **Sec. 805.** Ensuring provider access to best practices for combating prescription drug overdose.

- **Gone from 1st Draft:**
  - **Sec. 604.** Enhanced compliance with mental health and substance use disorder coverage requirements.
  - **Sec. 605.** Action plan for enhanced enforcement of mental health and substance use disorder coverage.
  - **Sec. 606.** Report on investigations regarding parity in mental health and substance use disorder benefits.
  - **Sec. 607.** GAO study on coverage limitations for individuals with serious mental illness and substance use disorders.
The bill does not designate the SAMHSA Administrator as an Assistant Secretary (or eliminate SAMHSA entirely), but it does detail SAMHSA program planning and recommendations duties for the Assistant Secretary of Planning and Evaluation (ASPE), create an Inter-Departmental Serious Mental Illness Coordinating Committee, and put various NIH directors on SAMHSA Advisory Councils.

Bill also:
- creates statutorily a Chief Medical Officer within SAMHSA;
- establishes grant programs for:
  - the treatment, recovery and transition of homeless individuals,
  - jail diversion programs, and
  - integration of primary care and mental health treatment;
- permanently authorizes the National Suicide Prevention Lifeline; and
- creates a National Treatment Referral Routing Service and a bed database.
HELP Committee Markup of Mental Health Reform Act of 2016 (cont’d)

- The draft does not change HIPAA, but requires the HHS Secretary to ensure providers, professionals, patients, and their families have adequate, accessible, and easily comprehensible resources on the appropriate uses and disclosures of protected health information under the HIPAA regulations.
  - Within one year, the Secretary must identify model training programs and materials for providers including, in the 2nd Draft, nurse practitioners and physician assistants.
- Within one year of finalizing the 42 CFR Part 2 revisions, the HHS Secretary must convene relevant stakeholders to determine the impact of those revisions on patient care, health outcomes, and patient privacy.
- Gone from 2nd Discussion (and presumably voted) Draft: Mandate that Secretary, within one year, issue guidelines on the application of parity principles to non-quantitative treatment limitations (NQTLs) on health benefits and, within 6 months, convene stakeholders to produce a compliance action plan.
  - Also gone: Requirement that parity enforcement actions be reported in annual reports posted on the Web.
In addition, the draft:

- requires a study within 2 years of peer support specialist programs and a report to Congress on best practices;
- creates state grants for child psychiatry telehealth access;
- creates state grants for early identification, and services for children and adolescents at risk of substance use disorders (SUD) and children and adolescents with co-occurring mental illness and SUD.
- creates state grants for residential treatment programs for pregnant and parenting women that also provide therapeutic, comprehensive child care for their children while mothers are engaged in therapy.

Most, but not all, grant programs are unfunded in the draft.

- Garrett Lee Smith Suicide Prevention TA Center funded at $6 million annually for 5 years ($1 million reduction).
- GL Smith Youth Suicide Early Intervention and Prevention Strategies funded at $30 million annually for 5 years ($5.4 million reduction).
- GL Smith Lifeline authorizes “such sums as may be necessary” for 5 years.
The draft would allow states to set aside 5 percent of the Mental Health Block Grant each year or 10 percent over two years, affording state flexibility. NASMHPD has registered support for this provision.

Some minor issues raised by NASMHPD with Committee Staff:

- State Plan requirements for block grants are lengthened and more detailed and are not tailored to each state’s particular uses of the very limited funds.
  - Committee accepted text tailoring some of the listed requirements to individual state’s intended use of block grant funds.
- The existing statutory maintenance of effort (MOE) standard—“material compliance”—is being replaced by a 97 percent compliance standard (the variance SAMHSA currently allows under SAPT block grant MOE guidance).
  - Committee, as NASMHPD suggested, returned to the original MOE language to provide SAMHSA with flexibility.
Democrats and Republicans are so irritated with Rep. Tim Murphy (R-PA), sponsor of H.R. 2646, and his resistance to compromise, they’re discussing waiting for the Senate bill rather than moving Rep. Murphy’s bill out of Committee.

Committee has not acted on bill since Health Subcommitteee markup on Nov. 3.
Senate Advances CARA (S. 524)

- Senate voted March 10, 94-1, to move forward with bipartisan S. 524, the Comprehensive Addiction and Recovery Act (CARA).
- Bill would authorize $77.9 million a year for Fiscal Years (FYs) 2016 through 2020 for grants awarded by the Health and Human Services Department (HHS) and the Justice Department (DOJ) to help families and communities dealing with addiction.
- It would specifically authorize $389.5 million FYs 2016 through 2020 for opioid abuse initiatives, though it wouldn’t appropriate new funds.
  - Amendment by Senator Jeanne Shaheen (D-NH) adding $600 million in funding was rejected 48-47, on a point of order.
- The bill would allow SAMHSA to use unspecified amounts for criminal justice activities for a 5-year period beginning on the date of enactment.
- States could receive as much as $100,000 for 1-year planning grants and as much as $5 million for 2-year implementation grants.
States that receive funding would be directed to:

- educate doctors about prescription guidelines and prescription drug monitoring programs (PDMPs);
- track delivery of prescription drugs and share data with other states;
- provide medication-assisted treatment and behavioral health therapy;
- screen individuals in therapy for HIV and hepatitis C, which can be spread when opioids are taken via injection;
- treat teenagers and young adults; and
- support programs to prevent overdose deaths.

Priority would be given to states that provide civil liability protection for the use of the overdose antidote naloxone, offer treatment services to prisoners, share and promptly update prescription monitoring data, and notify prescribers when there’s an indication of drug abuse.

Funded implementation grants would have to require prescribers and dispensers to register with the state’s PDMP and consult the PDMP database when providing a controlled substance.
Other funded measures would include:

- HHS grants to provide treatment as an alternative to prison.
- HHS grants for state substance abuse agencies to provide services for pregnant and postpartum women -- including women in the criminal justice system -- who have a substance use disorder.
- HHS grants to support young people recovering from substance abuse where eligible recipients would include high schools accredited by the Association of Recovery Schools, high schools seeking to establish or expand recovery services, institutions of higher education, collegiate recovery programs and nonprofit groups.
- HHS grants for nonprofit recovery community organizations governed by people who are recovering from a substance use disorder.
- HHS grants for medication-assisted treatment in areas with a high rate of or rapid increase in opioid use.
Other funded measures would include:

- DOJ grants to establish or expand disposal sites for unwanted prescription drugs;
- A Task Force on Recovery and Collateral Consequences established by DOJ to identify, and report within 1 year, collateral consequences resulting from a federal or state conviction for a drug-related offense.
- HHS grants to state, local, and tribal governments to teach first responders how to use drugs such as naloxone to reverse an opioid or heroin overdose.
- DOJ grants to support educational programs for offenders in prisons and juvenile facilities.
Sen. Dick Durbin’s (D-IL) S. 2605 would provide medical assistance to non-senior adult Medicaid recipients for inpatient services for addiction treatment services at qualified facilities.

Eligible facilities would be those that:

- provide substance abuse treatment services;
- are accredited by a national agency;
- have fewer than 40 beds (modifies the Medicaid IMD exclusion); and
- provide services to adults for up to 60 consecutive days.

S. 2605 also creates a 5-year, $50 million grant program to expand inpatient substance abuse treatment for Medicaid and CHIP recipients younger than 21 in medically underserved, high-risk, and rural communities.
New Guidance Document from CMS on Payment for IHS Facility Services

- **February 26 State Health Official Letter** updated Federal payment policy for Medicaid-eligible individuals who are American Indians and Alaska Natives (AI/AN) who receive services through Indian Health Service (IHS) facilities.

- Under the policy, IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements will be eligible for enhanced federal matching at a rate of 100 percent.

- The enhanced match will be available upon execution of the written care coordination agreement.
New Guidance Document from CMS on Payment for IHS Facility Services

- Previously, for the scope of services considered to be “received through” an IHS/Tribal facility and qualify for 100 percent FMAP, the service had to be a “facility service.”

- Under the new interpretation, the services that can be considered to be “received through” an IHS/Tribal facility for purposes of the 100 percent FMAP include any services the IHS/Tribal facility is authorized to provide under IHS rules that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS).

- Nothing in the guidance affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of a provider. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying for the 100 percent Federal match for those services.
This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan determined necessary to secure medical examinations and treatment for a beneficiary.

Related travel expenses include the cost of meals and lodging while in route to and from medical care and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary.

Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.
Guidance from CMS on Availability of HITECH Administrative Matching Funds in Connecting Meaningful Use Providers to Other Providers

- **February 29 State Medicaid Director Letter** updates guidance on the 90 percent matching rate for state expenditures on activities promoting health information exchanges (HIEs) and encouraging the adoption of certified Electronic Health Record (EHR) technology by Medicaid Eligible Providers.

- In 2013, CMS had said states’ costs of facilitating connections for providers to an HIE could be matched at the 90 percent rate authorized under the HITECH Act only if the providers connected were eligible for meaningful use incentives (“Eligible Providers”).

- CMS now says state costs of facilitating connections between Eligible Providers and *other* Medicaid providers through an HIE or other interoperable system, or costs of other activities that promote other Medicaid providers’ use of EHR and HIE, can also be matched at the 90 percent HITECH matching rate.

  - *But* to be eligible, State expenditures on the activities must still help the Eligible Providers meet the meaningful use objectives.
Guidance from CMS on Availability of HITECH Administrative Matching Funds in Connecting Meaningful Use Providers to Other Providers

- Subject to CMS prior approval, states may thus be able to claim 90 percent HITECH match for expenditures for connecting Eligible Providers to behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers.

- States are reminded that the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs.

- Still does NOT qualify providers previously not eligible for meaningful use incentives to receive those incentives.

- Guidance provides several non-exclusive examples of when the administrative match would be made available.
On March 16, CMCS released FAQs on the Methods for Assuring Access to Covered Medicaid Services final rule published November 2, which requires states to follow a transparent, data-driven process for documenting access to services covered under the Medicaid State Plan, consistent with § 1902(a)(30)(A) of the Social Security Act.

Among the services for which the FAQs say states must review access monitoring plans every three years and when provider reimbursement is reduced or restructured are behavioral health services (defined to include both mental health and substance use disorder services).

A state’s access monitoring review plan must identify data that will give insight into:

• the extent to which beneficiary needs are fully met,
• the availability of care through enrolled providers, and
• changes in beneficiary service utilization.

The final rule made it clear that increasing provider reimbursement should not be the default approach to correcting limited access.
On February 8, Reps. Fred Upton (R-MI), Joseph Pitts (R-PA), and Orrin Hatch (R-UT) sent CMS Acting Administrator Andy Slavitt a letter regarding a June 26, 2015 CMCS Informational Bulletin on using Medicaid for coverage of housing-related activities.

Bulletin had permitted use for

1. Individual Housing Transition Services - services that support an individual’s ability to prepare for and transition to housing;

2. Individual Housing & Tenancy Sustaining Services - services that support the individual in being a successful tenant able to sustain tenancy; and

3. State-level Housing Related Collaborative Activities - services that support collaborative efforts across public agencies and the private sector that assist a state in identifying and securing housing options.

The letter asks assurances that these services are not vulnerable to fraud, waste, and abuse, and are not duplicative of other federal programs that provide housing assistance.
Seven questions are posed, with responses “requested” in 45 days:

1. What peer-reviewed research or other analysis did CMS use to inform its thinking on the cost-effectiveness of Medicaid coverage of housing-related services, particularly populations not requiring LTSS coverage?

2. What, if any, criteria did CMS use in determining which housing-related services could be covered through Medicaid? For example, how did CMS determine that window coverings were appropriate for Medicaid coverage?

3. What controls are in place to ensure that the housing-related services and activities reimbursed through Medicaid are necessary, reasonable, and cost-effective?

4. How much money has been spent on housing-related services under Medicaid and for what populations?
5. What mechanisms does CMS have in place to prevent waste, fraud, and abuse in Medicaid coverage of housing-related services and activities?

6. According to the Department of Housing and Urban Development, homelessness declined by 11% since 2007 and the number of individuals experiencing homelessness declined by 31%, or almost 23,000 people, between 2010 and 2015. Please explain CMS’s rationale for focusing Medicaid coverage for housing-related services on persons experiencing chronic homelessness?

7. What is CMS doing to ensure Medicaid reimbursements are not duplicative of similar initiatives offered through other federal or state agencies? To what extent is CMS coordinating with other agencies? What steps is CMS taking to provide states with technical assistance in directing Medicaid beneficiaries to existing housing assistance programs in lieu of using Medicaid dollars?
HHS Awards Flint, Michigan Health Center Grants and § 1115 Waiver to Michigan

- Last month HHS Secretary Sylvia Burwell announced that two Flint, Michigan health centers would each receive $250,000 in emergency supplemental funding to hire staff to provide additional lead testing, treatment, outreach, and services for individuals who may have been poisoned by the lead-contaminated Flint water supply.
- On March 3, HHS approved a five-year § 1115 waiver to extend Medicaid coverage and services to Flint residents exposed to contaminated water.
  - Coverage under the waiver and a Federal match for children up to age 21 and pregnant women who have incomes up to 400 percent of the Federal Poverty Level (FPL).
  - State-only monies (no Federal match) will cover individuals with incomes above 400 percent FPL.
- HHS continues to work with several Federal agencies to help Flint residents remove the lead from their homes.
Utah HB 437, signed by Governor Gary Herbert March 25, will expand Medicaid under a waiver to:

- childless adults with incomes of less than 100% of the Federal Poverty Level, and
- if funding is available:
  - the chronically homeless,
  - individuals involved in the justice system through probation, parole, or court-ordered substance use disorder treatment,
  - individuals with mental health or substance use disorders in need of treatment.

Estimated the bill will serve 16,300 residents and cost approximately $100 million (including federal matching dollars).

Request for a waiver must be submitted to CMS by July 1, 2016.
Utah’s Suicide Study Legislation

- On March 22, Governor Herbert signed HB 440, requiring a study of the correlation between suicides and other violent deaths in the state in relation to use of firearms. Specifically, the bill requires the state suicide-prevention coordinator to:
  - investigate the number of deaths in the state that involved a gun (suicides, homicide, legal intervention, self-defense, domestic violence, and accidents);
  - determine in each instance how the gun was obtained and if it was legal;
  - gather demographic information regarding each shooter and his/her victim(s);
  - collect information on the shooter in each instance (ex. criminal involvement, history of domestic violence, mental health diagnosis); and
  - identify the total number of gun owners.