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National Association of State Mental Health Program Directors

Weekly Update

Bipartisan Opioid Legislation Posted by Conference Committee Creates 5-Year Exception to the Medicaid IMD Exclusion for Substance Use Disorder Treatment

The House is scheduled to approve today a Conference Committee's 660-page version of H.R.6, bipartisan comprehensive legislation to combat the opioid crisis.

A provision of the bill, posted late on September 25, would permit states to utilize the state plan amendment process to access a 5-year exception to the Medicaid IMD exclusion to provide substance use disorder treatment. Under the language of the provision, authored by Ohio Senators Rob Portman (R) and Sherrod Brown (D), Senator Ben Cardin (D-MD), and Senator Dick Durbin (D-IL), a state could permit a Medicaid-eligible individual to have access to 30 total days of care in an IMD during a 12-month period. In order for a state to utilize the exception, it would have to maintain state spending at the same levels on the substance use disorder treatment services being provided under the state plan amendment.

Language sought by Senator Joe Manchin (D-WV) which would have aligned 42 CFR Part 2 substance use disorder patient treatment information disclosure restrictions with disclosure restrictions under the Health Insurance Portability and Accountability Act (HIPAA) did not make it into the final Conference Committee Amendment. That language, contained within H.R. 6082, would also have increased penalties for prohibited disclosures in criminal proceedings and would have created penalties for prohibited disclsoures in civil proceedings. The coalition of dozens of insurers, patient and provider advocacy associations, health information exchange providers, and state official associations pushing for passage of the language will continue to push for Senate passage of the legislation, which passed the House 357-57 on June 20, before the end of the year.

In addition to the IMD provision, the Conference Committee version of H.R. 6, includes provisions:

- requiring state Medicaid programs to suspend, as opposed to terminate, a juvenile's Medicaid eligibility when a juvenile is incarcerated;
- requiring the Centers for Medicare and Medicaid Services (CMS) to carry out a demonstration to provide an enhanced federal match for state Medicaid expenditures used to expand substance use disorder treatment and recovery services; the demonstration would allow at least 10 states to receive planning grants and 5 states to be selected for the enhanced federal matching rate.
- requiring state Medicaid programs to have safety edits in place for opioid pharmacy refills, to monitor concurrent prescribing of opioids and certain other drugs, and to monitor antipsychotic prescribing for children;
- extending the enhanced matching rate for qualified activities for Medicaid health homes targeted towards Medicaid beneficiaries with substance use disorders from 8 quarters to 10 quarters for new SUD health homes;
- requiring state Medicaid programs to provide coverage for medication-assisted treatment;
- allowing states and localities to access state prescription drug monitoring program (PDMP) information, encouraging states to allow other states to access their PDMP data, and reauthorizing an HHS grant program to allow states to develop, maintain, or improve PDMPs and improve their interoperability;
- directing the Government Accountability Office (GAO) to submit a report on how Medicaid covers peer support services, including the types of services provided; payment models; states' experiences providing peer support services; and how states measure the extent to which peer support services improve costs and outcomes for beneficiaries;
- directing CMS to issue guidance to states on providing services via telehealth that address substance use disorders under Medicaid, including services addressing high-risk individuals, provider education through a hub-and-spoke model, and options for providing telehealth services to students in school-based health centers; *(Continued on page 4)*

House Approves 361-61, Sends to President, FY 2019 Funding for HHS, DOD

The House yesterday approved, 361-61, "minibus" legislation funding the Department of Health and Human Services and the Department of Defense in FY 2019. The legislation, which now goes to President Trump for signing, also continues funding through December 7 for any other Federal agency not expressly funded by Congress by September 30.

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- directing CMS to issue guidance on states' options for treating and managing beneficiaries' pain through non-opioid pain treatment and management options under Medicaid;
- modifying the "IMD exclusion" for pregnant and postpartum women to ensure that pregnant and postpartum women receiving care for substance use disorders in an IMD can continue to receive other Medicaid-covered care outside of the IMD, such as prenatal services;
- codifying regulations permitting managed care plans to cover treatment in an IMD for not more than 15 days in a month in lieu of other types of services;
- directing the Department of Health and Human Services (HHS) to issue a report on innovative state initiatives and covered housing-related services that state Medicaid programs may use to provide supports to Medicaid enrollees with substance use disorders who are experiencing homelessness or are at risk of homelessness, and directing HHS to provide technical assistance to states to develop and coordinate housing-related supports and services for Medicaid enrollees with substance use disorders;
- expanding the use of telehealth services by eliminating statutory originating site requirements for telehealth services furnished to Medicare beneficiaries for the treatment of substance use disorders and co-occurring mental health disorders, beginning on July 1, 2019, instead allowing payment for those services furnished via telehealth at originating sites, including a beneficiary's home, regardless of geographic location;
- requiring screening for opioid use disorder and other substance use disorders in Medicare beneficiaries during Medicare wellness and preventive care visits.
- requiring, by January 1, 2021, the use of e-prescribing under Medicare Part D and Medicare Advantage Prescription Drug Plans in the prescribing of opioids;
- expanding Medicare coverage to Opioid Treatment Programs (OTPs) for the purposes of delivering Medication-Assisted Treatment (MAT);
- requiring that CMS identify beneficiaries enrolled in Medicare Part D with a history of opioid-related overdose and include them in the definition of beneficiaries potentially at-risk for prescription drug abuse for purposes of enrollment under the Part D Drug Management Program;
- requiring the Food and Drug Administration (FDA) to hold at least one public meeting to address the challenges and barriers of developing non-addictive medical products intended to treat pain or addiction, and issue new, or update existing, guidance documents. FDA guidance may include clarifying how non-addictive medical products may qualify for expedited pathways;
- authorizing the Secretary of HHS to issue an order requiring manufacturers, importers, distributors, or pharmacists to cease distribution of a controlled substance if the Secretary determines there is a reasonable probability the controlled substance would cause serious adverse health consequences or death;
- clarifying FDA's authority to require drug manufacturers to package certain opioids to allow for a set treatment duration, such as a blister pack with a 3- or 7-day supply, and clarifying FDA authority to require manufacturers to give patients safe options to dispose of unused opioids;
- increasing the types of waivered health care providers that can prescribe or dispense medication-assisted treatment (MAT) by authorizing clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists to prescribe MAT for five years, making permanent the prescribing authority for physician assistants and nurse practitioners, and allowing waivered practitioners to immediately treat 100 patients at a time if the practitioner is board-certified in addiction medicine or addiction psychiatry or if the practitioner provides MAT in a qualified practice setting;

(Continued on page 6)

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Webinar: Addressing Addiction in Acute Care Settings

Wednesday, October 17, 2:00 p.m. E.T.

NEW!

Description: Emergency departments and acute inpatient medical hospitalizations represent a critical touch point during which interventions can both reduce harms associated with substance use and initiate treatment for substance use disorders. Often, the immediate complications of substance use are managed, but the underlying disorder is left largely untreated.

This webinar aims to describe programs that are currently underway including the supportive evidence to capitalize on the time that a patient spends in the acute care setting to promote health and therapeutic engagement while minimizing future harm. Optimizing these treatment strategies will improve patient care and satisfaction while reducing unnecessary resource utilization.

Presented by: Michael Lynch, MD. Dr. Lynch is a board certified emergency physician and medical toxicologist. He is the medical director of the Pittsburgh Poison Center and works clinically in two level one trauma center EDs and as a clinical toxicologist at 5 hospitals. He has led efforts to improve care for patients with substance use disorders both in the ED and in the hospital coupled with connection to ongoing treatment.

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- clarifying FDA's post-market authority for drugs, such as opioids, which may have reduced efficacy over time, by modifying the definition of an adverse drug experience to include reduced effectiveness and authorizing new information related to reduced effectiveness to be included in the requirements for additional studies of a drug that the Secretary determines should be included in the label;
- authorizing the Department of Labor to award dislocated worker grants to states through the Workforce Innovation and Opportunity Act to support local workforce boards and local partnerships in tackling shortages in substance use disorder and mental health treatment workforce and provide coordinated job training and treatment services to individuals in affected communities with opioid or substance use disorder;
- providing grants for new comprehensive opioid recovery centers that are to serve as community resources, with the option of using the ECHO model utilizing tele-technology;
- establishing a demonstration program to test alternative pain management protocols to limit the use of opioids in hospital emergency departments, and provide technical assistance to acute care settings, including hospital emergency departments on best practices on alternatives to opioids for pain management;
- providing more early intervention with vulnerable children who have experienced trauma by:
  - authorizing the Centers for Disease Control and Prevention to support states' efforts to collect and report data on adverse childhood experiences through existing public health surveys; and
  - creating an interagency task force to recommend best practices for identifying, preventing, and mitigating the effects of trauma on infants, children, youth, and their families., requiring the task force to develop a set of best practices and national strategy and identify existing federal authorities and grant programs where trauma-informed practices are allowable.

Clarke Ross

From: NASADAD <rmorrison@nasadad.org>
Sent: Thursday, September 27, 2018 3:50 PM
To: clarkeross10@comcast.net
Subject: D.C. Update from the National Association of State Alcohol and Drug Abuse Directors

September 27, 2018

The National Association of State Alcohol and Drug Abuse Directors D.C. Update

Opioids legislation, new SAMHSA resources, and more

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Capitol Hill Happenings

House and Senate leaders announce opioid legislation agreement

On Tuesday, House and Senate lawmakers announced an agreement on legislation to address the opioid crisis. This legislative agreement combines and reconciles differences between previously passed House and Senate bills.

The latest version of the SUPPORT for Patients and Communities Act (H.R. 6) includes a variety of provisions, some of which include:

- Reauthorizing grants to States to address the opioid crisis (previously authorized in the 21st Century Cures Act of 2016), and adding to the grant program a 5% set-aside for Indian tribes, as well as up to a 15% set-aside for States and Tribes with the highest age-adjusted rate of drug overdose deaths based on CDC data. The bill authorizes $500 million for each of FY 2019 - FY 2021.
- Establishing a grant program for emergency rooms to create a protocol to support individuals who have survived an opioid overdose, including having onsite peer recovery coaches.
- Creating a grant program to establish at least 10 Comprehensive Opioid Recovery Centers (CORCs) throughout the U.S.
- Developing and disseminating best practices for recovery housing.
- Student loan repayment for SUD treatment professionals in mental health professional shortage areas or counties that have been hardest hit by drug overdoses.
- Reauthorizing the Office of National Drug Control Policy (ONDCP), as well as the Drug-Free Communities (DFC) and High-Intensity Drug Trafficking Areas (HIDTA) programs.
- Reauthorizing SAMHSA's Residential Treatment for Pregnant and Postpartum Women (PPW) program for FY 2019-FY 2023.

The House will likely vote on the final version of the SUPPORT Act before the end of this week,

Congress Reaches Final Opioid Crisis Deal

Your source for the latest updates from Capitol Hill. We translate policy into practice so you can learn how policy trends will affect your work and how best to prepare.

Stephanie Pellitt
Policy Associate, National Council for Behavioral Health

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This week, House and Senate leaders announced an agreement on legislation to address the nation's opioid addiction crisis. The bipartisan agreement (**H.R. 6**) supports many National Council priorities, including expanding access to treatment, strengthening the behavioral health workforce and supporting behavioral health information technology. The package also reveals the fate of controversial measures on the Institutions for Mental Disease (IMD) rule and the privacy of substance use disorder (SUD) treatment records that Congressional lawmakers and staff have worked through over the last several weeks.

REACTION

While the National Council for Behavioral Health (National Council) is pleased to see many important policy changes included in the final opioid package, it ultimately falls short on providing desperately needed long-term investments in prevention, treatment and recovery services. In particular, the National Council is disappointed that Congress missed this opportunity to expand the current eight-state, two-year **Certified Community Behavioral Health Clinic (CCBHC)** program via the Excellence in Mental Health and Addiction Treatment Expansion Act. This program has shown **tremendous results** in expanding access to comprehensive addiction services in a sustainable way.

WHAT'S IN?

Throughout Congress' efforts to address the opioid crisis, the National Council has been advocating for a number of important measures, many of which have been included in the final compromise bill:

The National Council was pleased to see the following measures in the package:

- **The Special Registration for Telemedicine Clarification Act** will remove barriers to accessing medication-assisted treatment (MAT) for opioid use disorders via telemedicine in rural and frontier areas and is a direct result of **National Council advocacy efforts**.
- **The Substance Use Disorder Workforce Loan Repayment Act** will create incentives for students to pursue addiction treatment careers, increasing timely access to treatment for individuals living with addiction. This legislation was introduced as a result of education and advocacy by the National Council and the Association for Behavioral Healthcare in Massachusetts.
- **Improving Access to Behavioral Health Information Technology Act** incentivizes behavioral health providers to adopt electronic health records (EHRs). The National Council has been working for passage of this legislation since 2009, when behavioral health was left out of a law that created financial incentives for providers and hospitals to implement EHR systems to improve patient care.
- **Ensuring Access to Quality Sober Living Act** requires the Substance Abuse and Mental Health Services Administration to disseminate best practices for operating recovery housing to states and help them adopt those standards. The National Council has been a longtime supporter of imposing more robust standards. To this end, in partnership with the National Alliance for Recovery Residences, we recently issued *Building Recovery: State Policy Guide for Supporting Recovery Housing* to assist states with the creation of recovery housing certification programs that standardize recovery housing operations to protect and support residents.
- **Improving Access to Mental Health Services Act** will allow behavioral health National Health Service Corps participants to work in schools and other community-based

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settings, thereby lowering barriers to access, particularly for rural and frontier communities.

- **MAT Prescribing Expansions:** The packages pulls a provisions from the **TREAT Act** and the **Addiction Treatment Access Improvement Act** to expand access to **medication-assisted treatment (MAT)**, which is considered the gold standard of opioid use disorder treatment. Together, these measures will: 1) eliminate the sunset date for nurse practitioners' (NPs) and physician assistants' (PAs) prescribing authority for buprenorphine (a MAT medication), 2) temporarily expand the definition of "qualifying practitioner" to prescribe buprenorphine to include nurse anesthetists, clinical nurse specialists, and nurse midwives, 3) permit **a DATA-2000 waivered-practitioner** to start immediately treating 100 patients at a time with buprenorphine (in lieu of the initial 30 patient cap) if the practitioner meets certain requirements, and 4) codify a change that expanded the number of patients that a physician can treat with buprenorphine at any one time to 275 patients, up from 100 patients. A separate provision would also ensure physicians who have recently graduated in good standing from an accredited school of allopathic or osteopathic medicine, and who meet the other training requirements to prescribe MAT, can obtain a waiver to prescribe MAT.
- **Medicare SUD Treatment Access:** The bill creates a demonstration project that would allow Medicare beneficiaries to receive MAT and certain wraparound services at an Opioid Treatment Program (OTP), also known as a methadone clinic. Currently, OTPs are not recognized as Medicare providers, meaning that Medicare beneficiaries receiving MAT at OTPs must pay out-of-pocket.
- **IMD Rule Changes:** The National Council was pleased to see a provision to temporarily repeal the Institutions for Mental Disease (IMD) exclusion, a policy that prohibits Medicaid payment for residential SUD and mental health care in facilities with more than 16 beds, broadened to cover residential treatment of all substance use disorders, rather than just opioid use disorders. The repeal would last for five years, and cover patient stays of up to 30 days within the previous 12 months. The provision also contains strict **maintenance-of-effort requirements**. Again, the National Council is disappointed to see little investment in community-based services that ensure patients can maintain a successful recovery after exiting inpatient treatment.

A controversial measure to loosen 42 CFR Part 2, the regulation governing the privacy of SUD treatment records, was not included in the final bill.

The final compromise opioid package contains over 70 opioid-related bills. For a more comprehensive summary of the package's provisions, please see the **section-by-section summary here.**

WHAT'S NEXT?

The House is expected to vote on the conference opioid package as early as today (9/28). The Senate would then vote on the package in October, sending the legislation to the President's desk before the midterm elections in November 2018.

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