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# H.R.2646 - Helping Families in Mental Health Crisis Act of 2015

114th Congress (2015-2016) | [Get alerts](#)

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**Sponsor:** [Rep. Murphy, Tim \[R-PA-18\]](#) (Introduced 06/04/2015)

**Committees:** House - Energy and Commerce; Ways and Means; Education and the Workforce

**Latest Action:** 11/16/2015 Referred to the Subcommittee on Early Childhood, Elementary, and Secondary Education. ([All Actions](#))

**Tracker:**

Introduced	Passed House	Passed Senate	To President
	Became Law		

**More on This Bill**

- [Constitutional Authority Statement](#)
- [CBO Cost Estimates](#)

**Subject — Policy Area:**

- Health
- [View subjects](#)

<b>Summary (1)</b>	Text (1)	Actions (13)	Titles (2)	Amendments (0)	Cosponsors (184)	Committee
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## Summary: H.R.2646 — 114th Congress (2015-2016) [All Bill Information](#) (Except Text)

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There is one summary for H.R.2646. [Bill summaries](#) are authored by [CRS](#).

**Shown Here:**

Introduced in House (06/04/2015)

### Helping Families in Mental Health Crisis Act of 2015

This bill creates the position of Assistant Secretary for Mental Health and Substance Use Disorders to take over the responsibilities of the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA). Mental health programs are extended and training regarding mental health is expanded.

SAMHSA must establish the National Mental Health Policy Laboratory and the Interagency Serious Mental Illness Coordinating Committee.

This bill amends the Public Health Service Act to require the National Institute of Mental Health to translate evidence-based interventions and the best available science into systems of care.

Certain mental health care professional volunteers are provided liability protection.

Pediatric mental health subspecialists are eligible for National Health Service Corps programs.

An underserved population of children or a site for training in child psychiatry can be designated as a health professional shortage area.

The protected health information of an individual with a serious mental illness may be disclosed to a caregiver under certain conditions.

This bill amends title XIX (Medicaid) of the Social Security Act (SSAct) to conditionally expand coverage of mental health services.

Part D (Voluntary Prescription Drug Benefit Program) of title XVIII (Medicare) of the SSAct is amended to require coverage of antidepressants and antipsychotics.

If it will not increase Medicare spending, Medicare's [190](#)-day lifetime limit on inpatient psychiatric hospital services is eliminated.

Health information technology activities and incentives are expanded to include certain mental health and substance abuse professionals and facilities.

This bill restricts the lobbying and counseling activities of protection and advocacy systems for individuals with mental illness. These systems must focus on safeguarding the rights of individuals with mental illness to be free from abuse and neglect.

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## S.1945 - Mental Health Reform Act of 2015

114th Congress (2015-2016) | [Get alerts](#)

**BILL** [Hide Overview](#)

**Sponsor:** [Sen. Cassidy, Bill \[R-LA\]](#) (Introduced 08/05/2015)

**Committees:** Senate - Health, Education, Labor, and Pensions

**Latest Action:** 08/05/2015 Read twice and referred to the Committee on Health, Education, Labor, and Pensions. ([All Actions](#))

**Tracker:**

<b>Introduced</b>	Passed Senate	Passed House	To President
	Became Law		

**Subject — Policy Area:**  
Health  
[View subjects](#)

- Summary (1)**
- Text (1)
- Actions (1)
- Titles (2)
- Amendments (0)
- Cosponsors (15)
- Committees (0)

### Summary: S.1945 — 114th Congress (2015-2016)

[All Bill Information](#) (Except Text)

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There is one summary for S.1945. [Bill summaries](#) are authored by [CRS](#).

**Shown Here:**

Introduced in Senate (08/05/2015)

#### Mental Health Reform Act of 2015

This bill creates the position of Assistant Secretary for Mental Health and Substance Use Disorders to oversee the Substance Abuse and Mental Health Services Administration (SAMHSA). Mental health programs are extended and training regarding mental health is expanded.

SAMHSA must establish the National Mental Health Policy Laboratory and the Interagency Serious Mental Illness Coordinating Committee.

This bill amends the Public Health Service Act to require the National Institute of Mental Health to translate evidence-based interventions and the best available science into systems of care.

The Health Resources and Services Administration must support the creation and expansion of child psychiatry access programs.

Certain mental health care professional volunteers are provided liability protection.

Pediatric mental health subspecialists are eligible for National Health Service Corps programs.

An underserved population of children or a site for training in child psychiatry can be designated as a health professional shortage area.

SAMHSA must award primary care and behavioral health care integration grants to state entities to fund improvements in settings with integrated care.

The Department of Health and Human Services must develop a model program and materials for training health care providers regarding the disclosure of the protected health information of patients with a mental illness.

This bill amends title XIX (Medicaid) of the Social Security Act to conditionally expand coverage of mental health services.

# ACTION PAPER

## Addressing the Disparate Impact of the Federal Response to the Opioid Epidemic

*By Daniel J. Mistak, J.D., General Counsel, Community Oriented Correctional Health Services*

### Introduction

When Medicaid was established in 1965, federal financial participation (FFP) was prohibited for health care services provided to individuals in Institutions for Mental Disease (“IMDs”) and inmates of a public institution (the “Inmate Exception”).<sup>1</sup> These exclusions served important roles in the advent of nationwide indigent health care: they created disincentives for ineffectual and inhumane institutional treatment of individuals with mental health needs, and they avoided incentives for local jurisdictions to transfer their own health care costs to the newly minted state-federal payment system.

Much has changed since 1965. The advent of the Patient Protection and Affordable Care Act (ACA); public health policy’s focus on the Triple Aim of individual health, population health, and cost containment; a growing opioid abuse epidemic; and better understanding of treatment regimes have led to a reassessment of whether providing Medicaid coverage for services in IMDs still poses the same risks it did in 1965. On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) released a letter (“IMD Letter”) to state Medicaid directors inviting them to craft 1115 Medicaid waivers to enable states to use IMDs as a part of a comprehensive plan to tackle the opioid abuse epidemic.<sup>2</sup> This letter opened the door to Medicaid reimbursement for care plans that include residential treatment.

1115 waivers crafted under the new CMS guidance, however, would still leave large numbers of people affected by the opioid epidemic without access to the health care necessary for recovery. These are individuals who have been placed into jails and prisons as a result of their addiction. Indeed, without an accompanying letter from CMS that encourages states to draft narrowly crafted 1115 waivers for services that would typically fall within the Inmate Exception, the racial disparities that exist within our health and public safety systems could increase. Given the historical context and the racialized consequences of not addressing the needs of people in the criminal justice system, CMS should invite states to craft a narrow waiver of the Inmate Exclusion similar to the IMD waiver. This Action Paper describes the historical context of the IMD and Inmate Exception and provides recommendations for policy changes that could both combat the opioid epidemic and reduce racial and economic disparities that would be a consequence of failing to address the entire population affected by the opioid epidemic.

### Background to IMD and the Inmate Exception

The federal government has had many reasons to be skeptical of incentivizing the creation of facilities that would cordon individuals off from the community. Arguably, the process of “deinstitutionalization” began in 1955 with the introduction of the anti-psychotic medication Thorazine.<sup>3</sup> Ten years later, the introduction of Medicaid and Medicare provided a driving force for further deinstitutionalization by codifying the IMD and Inmate Exclusions into law. Following the revelations in the 1970s of the horrors at Willowbrook State School in Staten



Island—where developmentally disabled individuals were warehoused under appalling conditions—and the Supreme Court’s seminal decision in *Olmstead v. L.C.*<sup>4</sup> in 1999, public and governmental opinion were decidedly opposed to the overuse of institutional settings.

The history of IMDs follows a different track than the history of inmates of public institutions. While the IMD Exclusion incentivized treatment in the community, the Inmate Exception kept health care costs for correctional facilities off the federal ledgers. Health care costs for individuals who were held in state and county facilities, such as jails and prisons, were the responsibilities of those jurisdictions, and the Inmate Exception aimed to keep it that way. In 1976, the Supreme Court ruled that correctional facilities that were deliberately indifferent to the serious medical needs of incarcerated individuals violated the Eighth Amendment to the Constitution,<sup>5</sup> but the Inmate Exception meant that the costs of adequate health care would always remain state or local costs.

The combination of these two exclusions created a two-tiered response to behavioral health needs. For individuals with behavioral health needs, the struggle for effective community treatment continued—and still continues to this day—but FFP was not denied as long as treatment was not provided in an IMD. For individuals with behavioral health needs that resulted in entanglement in the criminal justice system, including substance use disorder—which only received treatment parity with the advent of the ACA—the benefits of services funded by FFP were removed. IMDs shrank, but correctional facilities became warehouses for individuals with behavioral health needs and no health care.

Today we see that jails have become *de facto* behavioral health facilities. In these institutions, public safety takes precedence over the effective treatment of behavioral health conditions—minimizing the possibility of effectively meeting the health needs of these individuals or helping avoid recidivism. Studies estimate that fourteen percent of male inmates and thirty-eight percent of female inmates meet the criteria for serious mental illness (SMI), compared to five percent in the general population.<sup>6</sup> Sixty-eight percent of jail inmates demonstrate signs of substance use disorder.<sup>7</sup> It is estimated that two-thirds of the people that leave correctional facilities will be arrested again.<sup>8</sup> The implication is clear: Individuals in correctional facilities are not having their behavioral health care needs met. Upon release from the facility, their unmet needs mean that they will repeat the behaviors that resulted in their initial entanglement in the criminal justice system.

This dual track is even more significant when considering the racial disparities of our correctional system. Correctional facilities disproportionately hold young, poor, people of color. Collectively, black and Hispanic populations are twenty-four percent of the general population, but comprise fifty-four percent of the jail population. A black male born in 2001 has a thirty-two percent chance of spending time in prison at some point in his life. A Hispanic male has a seventeen percent chance. A white male, on the other hand, only has a six percent chance.<sup>9</sup>

### CMS Response to Opioid Crisis: A New Look at IMDs

Today, CMS and others are recognizing the need to change their approach to IMDs. Fifty years after the Social Security Act was passed, we have entered a new era that is reshaping the way health care is delivered, conceptualized, and administered. Since the 1960s, we have come to understand that addiction is an illness, and not a moral failing. This means that we need new approaches to addiction crises. The opioid abuse epidemic has become the example *par excellence* of our evolving understanding of addiction and drug abuse. New tools, such as the American Society of Addiction Medicine’s (ASAM) diagnostic criteria for acuity of treatment, provide elegant means of assessing and responding to the needs of individuals struggling with addiction. Indeed, the evolution of our response to substance

abuse needs has re-surfaced questions regarding the utility of IMDs. For example, according to the ASAM criteria, under certain DSM-IV diagnoses and levels of acuity, the appropriate treatment regime should include a short stay in an IMD to effectively administer addiction treatment.

At the same time, we have come to understand that health care is best delivered through what public health professionals call the Triple Aim: individual health, population health, and controlling costs. All three parts of the Triple Aim must be undertaken simultaneously—otherwise, the optimal outcomes will remain elusive. Tackling the opioid abuse epidemic means not merely looking at the individual health of a consumer of health care services, but also at population health outcomes. If the health of the population as a whole is not considered, individual health and cost savings will both suffer.

This evolution in science and policy has placed CMS in a difficult situation. The ASAM criteria clearly indicate that IMD services are necessary for some individuals with substance use disorder. To effectively combat the opioid abuse epidemic, CMS can no longer act as though an IMD is never appropriate for both health outcomes and health care savings. CMS' initial response to the opioid epidemic has been laudable. On July 27, 2015, CMS invited states to use their 1115 Medicaid waiver authority to include IMDs into the full panoply of services available to states in their attempt to combat the opioid abuse epidemic. CMS has recognized the value of IMDs in treating crises and in addressing substance use disorders.

### The Inmate Exclusion

CMS' efforts, however, still fail to provide a means of treatment for a significant portion of the population affected by the opioid use epidemic. As noted above, many of the individuals in jail, who are disproportionately people of color, are there because of untreated behavioral health disorders—including substance use disorders. Without creating a waiver that would cover the entire population affected by the opioid epidemic, CMS will fail to effectively address the population health impacts of the opioid abuse epidemic. Further, the separate courses created by the IMD and Inmate Exclusion described above are further exacerbated by this new policy. Many media outlets are already beginning to point out that the loosening of the IMD restrictions only occurred upon the advent of the current prescription-opioid fueled heroin epidemic, which has been largely affecting suburban and white populations.<sup>10</sup>

Understandably, it would be bad policy to allow all health care services in the jail to receive FFP, but CMS can limit the opportunities for exploitation of FFP by inviting states to craft narrow waivers that would target FFP in certain circumstances. CMS already attempted to limit the perverse incentives that would be associated with opening the flow of FFP to IMDs by requiring that IMDs merely be one part of a comprehensive Substance Abuse Treatment. In the same fashion, a narrowly crafted waiver of the Inmate Exclusion could eliminate the perverse incentives associated with allowing FFP to flow to inmates of a public institution.

### Conclusion: The Inmate Exclusion Waiver and its Implications

There are four clear ways that FFP could improve the health status of the population affected by the opioid abuse epidemic, while simultaneously improving individual health status, and decreasing the costs of combating the epidemic. A narrow Inmate Exclusion waiver would:

1. Allow states and counties to use FFP to work with Medicaid providers to both identify patients in county jails who are receiving community-based opiate treatment and to maintain their treatment protocols. Better coordinating care would reduce the risk that inmate progress outside the jail would be squandered once inside the jail, thereby

reducing both Medicaid spending and health disparities for justice-involved beneficiaries.

2. Allow states and counties to use FFP for Medicaid providers to work with county jails to develop opioid treatment and continuity of care plans for released or diverted individuals subject to the ASAM criteria. Access to care upon release or diversion from jail is essential to good health outcomes – especially in the crucial 24-to-72 hours immediately following release or diversion. Delays in reactivating Medicaid increase overall Medicaid costs, lead to treatment interruptions and can adversely impact communities, especially when access to opioid treatment is hindered. Allowing the use of FFP to prescribe and dispense treatment prior to the point of release or diversion would reduce Medicaid spending and improve the health and safety of individuals and communities.
3. Allow states and counties to use FFP to initiate medication-assisted therapy or other forms of medically necessary and appropriate intervention for jailed individuals with opiate addiction whose release is anticipated within 7-to-10 days. Many individuals booked into county jails have previously undiagnosed and untreated disorders. Allowing FFP to be used to cover the costs of treatment prior to release would prevent medical disorders from deteriorating upon release and save federal dollars. A disproportionate number of unintentional overdoses occur after release from jail. Planned interventions can avoid these tragedies and improve overall health outcomes.
4. Allow states and counties to use FFP to reimburse peer counselors to facilitate reentry and increase jailed individuals' health literacy. The Center for Medicare and Medicaid Innovation has invested in a peer counseling demonstration project through the Transitions Clinic Network, which has already demonstrated lower rates of Emergency Department visits for individuals who participate in its program.<sup>11</sup>

A letter from CMS encouraging states to develop 1115 waivers with these components is not only essential for combatting the public health crisis that is the opioid abuse epidemic, but it is also essential to ensuring that the IMD waivers will not have the unintended consequence of increasing racial disparities.

## Endnotes

<sup>1</sup> See The Social Security Act, 42 U.S.C. § 1396d(i) (1965) (describing the IMD). See also, 42 U.S.C. § 1396d(a)(29)(A) (describing the Inmate Exception). See also, 42 C.F.R. § 435.1009(a)(1)-(2) (stating “FFP is not available in expenditures for services provided to [i]ndividuals who are inmates of public institutions . . . or [i]ndividuals under age 65 who are patients in an institution for mental disease”).

<sup>2</sup> Letter from Vicky Wachino, Director, Centers for Medicare & Medicaid Services, to State Medicaid Directors (July 27, 2015), <http://medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf>.

<sup>3</sup> See E. Fuller Torrey, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* (1997).

<sup>4</sup> 527 U.S. 581 (1999).

<sup>5</sup> *Estelle v. Gamble*, 429 U.S. 97 (1976).

<sup>6</sup> Henry Steadman, et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 *PSYCH. SERVS.* 761 (2009).

<sup>7</sup> Jennifer C. Karberg, *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002*, Bureau of Justice Statistics (2006).

<sup>8</sup> Andrew Papchristos, *Recidivism and the Availability of Health Care Organizations*, 3 *JUST. Q.* 31 (2014).

<sup>9</sup> Thomas P. Bonczar, *Prevalence of Imprisonment in the U.S. Population, 1974-2001* (Bureau of Justice Statistics, August 2003).

<sup>10</sup> See, e.g., Andrew Cohen, *How White Users Made Heroin a Public-Health Problem*, *ATLANTIC MONTHLY*, August 12, 2015; and Katharine Q. Seelye, *In Heroin Crisis, White Families Seek Gentler War on Drugs*, *N.Y. TIMES* Oct. 30, 2015 at A1.

<sup>11</sup> Emily A. Wang, et al., *Engaging Individuals Recently Released From Prison Into Primary Care: A Randomized Trial*, 102 *AM. J. OF PUB. HEALTH* e22-e29 (Sept. 2012).

# UNDER THE MICROSCOPE

MARCH 1, 2016



## TAKING ACTION TO REDUCE THE OPIOID USE EPIDEMIC

### ISSUE

According to the most recent statistics from the Centers for Disease Control and Prevention (CDC), more than 47,000 Americans died from abuse of opioids, including prescription pain medications and heroin, in 2014. Addressing this deadly epidemic involves tools such as evidence-based prevention programs, prescription drug monitoring, prescription drug take-back events, medication-assisted treatment using products like buprenorphine, and expanded availability of the overdose reversal drug Narcan (naloxone).

“There’s one issue on which politicians agree: We’ve got to do more about the Nation’s drug problems, specifically with addiction to prescription opiates and heroin,” said Tom Renfree, Deputy Director, Substance Use Disorder Services for the County Behavioral Health Directors Association of California, who addressed NACBHDD’s 2016 Legislative and Policy Conference in Washington, DC in February. The incidence of these addictions has risen sharply since 2002, he added, noting that a prescriber awareness initiative launched in 2012 has helped to slow the growth of addiction to prescription opiates, the substances on which four in five current heroin addicts start their opiate addiction. However, greater caution on the part of some prescribers has been overcome at present by the surging availability of relatively cheap, high-quality heroin, which has continued to fuel the overall rise in opiate addiction. Increasing use of heroin corresponds with a continued sharp increase in opiate overdoses. In California alone, he notes, one individual overdoses every 45 minutes.

“The problem is not limited to urban areas. It’s also been a huge problem in rural areas and with all ages and demographics. The problem has been so significant among young and middle-aged white men that there’s been said to be a “gentrification” of opioid addiction,” said Renfree. He added that while the concept of gentrification smacks of past negative stereotypes about drug abusers and their needs for treatment, the explosion of addiction among white males has, at last, led to a broad push for more available and less-punitive treatment practices.

### ANALYSIS

#### Opioid prevention and treatment strategies

“The fight against opioid abuse is being undertaken on many fronts,” said Renfree, who outlined the policies being pursued by state and federal officials. Key steps include:

**Prescription drug monitoring programs (PDMPs)**, to enable physicians to identify opiate prescriptions by patient name and prevent patients from getting multiple opiate prescriptions from

multiple doctors. Many states have or are considering laws to mandate PDMP by physicians, though state and national medical organizations have protested against such mandates, arguing that they are costly in terms of physician time.

**Continued expansion of prescriber education regarding pain management and addiction.**

Renfree cited a study that noted 60 percent of primary-care providers and 65 percent of pain management specialists felt that they were only “somewhat” prepared to identify likely opiate misusers and fewer said that they were comfortable in addressing addiction-related issues. Much additional training is needed in this area.

**Development of “abuse-deterrent” opiate medication formulations** that make it difficult or impossible for would-be abusers to crush or concentrate the active ingredient in a way that would facilitate abuse.

**Increased access to the opioid overdose antidote Narcan (naloxone).** More and more states have passed or are considering legislation to allow the furnishing of naloxone doses without prescription to third parties, such as family members or friends of active opiate users, and for training in naloxone administration to be provided by emergency response personnel to police and members of the general public.

**Linking opioid overdose survivors to treatment.** Renfree noted that while administering Narcan saves lives by preventing overdose deaths, overdose survivors must be linked to treatment if they are to have any chance for recovery. To this end, more and more hospitals that treat opiate overdoses are coordinating with health officials and treatment providers to link survivors directly to peer coaches during the course of emergency department treatment.

**Expanding treatment resources.** Historically, 90 percent of California’s addiction treatment capacity has been in beds covered by the institution for mental disorders (IMD) exclusion, which bars Medicaid reimbursement for treatment of adults in specialized mental health or addiction treatment facilities that have more than 16 beds. “This has been a huge barrier to expanding addiction treatment services,” said Renfree.

But during 2015, California negotiated an innovative 1115 Drug MediCal Organized Delivery System (ODS) waiver with CMS, the first of its kind in the country. Among the key conditions of the waiver:

- Residential treatment can be provided to all eligible MediCal beneficiaries in facilities of any size in counties that opt into the ODS waiver.
- Services are provided in licensed and certified residential facilities that are designated to meet ASAM treatment criteria.
- 90-day maximum length of stay for adults (max of two stays per year); 30 days for adolescents, with a one-time 30 day extension based on medical necessity within a one-year period. Perinatal and criminal-justice-involved clients may be eligible for longer stays, based on medical necessity.

- Counties provide authorization for treatment services, and county implementation plans must assure that, within three years of CMS approval, the care that their facilities provide meets ASAM residential treatment criteria.
- Counties now are able to file patient claims for multiple Drug MediCal services in a single day, so that, for example, a patient can receive methadone as well as an outpatient service, on the same day. This is particularly helpful for those in rural areas who face scheduling or transportation challenges.

“The Drug MediCal ODS waiver is huge for us in California because we’ve never been able to offer residential treatment that has had MediCal funding,” Renfree explained. “We’re already seeing many additional treatment programs seeking Drug MediCal certification to become providers.” If the program continues to work out as hoped, he said that it will not only dramatically expand available addiction treatment, but will also “help to free up block grant funding for other services such as recovery supports and housing.”

The waiver also has provisions to allow for Medication Assisted Therapy (MAT) with a required counseling component. The MAT formulary will offer a full range of medications—methadone, naltrexone, buprenorphine, naloxone, and disulfiram. “Buprenorphine treatment is still not as accessible as we want it to be,” he continued, noting that prescribing physicians continue to be limited by caps on the number of individuals that they can treat with buprenorphine – typically 100. He also supports a push to expand the range of qualified MAT providers by expanding prescribing privileges to specially trained nurse practitioners and physician assistants. Expanding prescribing privileges to these two groups is the focus of a pilot program in President Obama’s \$1.1 billion FY 2017-18 proposal to improve opiate addiction treatment nationwide (see below).

As California pursues greater treatment capacity, it continues to battle ongoing attitudinal, policy, and regulatory barriers. Treatment providers continue to hold negative views about patients that use MAT and to be hindered by fail-first policies, medication limits, minimal allowance for follow-up recovery counseling, frequent reauthorizations of ongoing treatment, and other similar issues. Interestingly, a number of California’s narcotic treatment programs (NTPs) are considering the merits of becoming health homes, providing integrated care for those with opiate dependency. A number of the larger NTPs are seriously evaluating this approach, says Renfree. He explained that, “they’re already seeing their patients every day (for methadone), physicians are already working in these programs, so the addition of primary care services would be just one more step.”

### **Obama proposes \$1.1 billion for opiate addiction treatment in 2017 and 2018**

Tom Hill, SAMHSA’s Senior Advisor for Addiction and Recovery and Acting Director of the Center for Substance Abuse Treatment (CSAT), also joined NACBHDD’s February Legislative and Policy Conference to outline President Obama’s \$1.1 billion proposal to expand opioid use prevention and treatment. The proposal would:

- Target \$920 million--\$460 million each year for FY 2017 and 2018—to support cooperative agreements with states to expand access to MAT for opioid use disorders. States will receive funds based on the severity of the epidemic and on the strength of their strategy to respond to it. States can use these funds to expand treatment capacity and make services more affordable.
- Offer \$50 million in National Health Service Corps funding to expand access to substance use treatment providers. This funding will help support training of approximately 700 providers able to

provide substance use disorder treatment services, including MAT, in areas suffering the highest rates of addiction.

- Provide \$30 million to evaluate the effectiveness of treatment programs employing MAT under real-world conditions and help identify opportunities to improve treatment for patients with opioid use disorders.
- Fund a \$10 million demonstration project to expand the availability of buprenorphine treatment by enabling advanced practice personnel, specifically nurse practitioners and physician assistants, to prescribe the medication.
- Provide \$12 million in funding to be used to acquire the overdose antidote Narcan (nalaxone).

Hill added that the opiate abuse epidemic has focused policymaker concern around the need for updated education and prescriber guidance regarding the use of opiate medications for pain management. He said that the CDC is “in the final stages” of producing new opiate prescribing guidelines. At the same time, DHHS secretary Sylvia Burwell is focusing on expanding awareness among health professionals to better understand addiction problems and refer patients for addiction treatment, and on possible reforms that would make laws more responsive to the needs of people coping with addictions and recovering through MAT. Among the justice related reforms likely in 2017 is a push by SAMHSA to bar discrimination by the Nation’s drug courts against defendants who are participating in MAT programs.

## **ACTION STEPS**

The following are steps you can take to address this problem in your own county:

- 1) Review state and local plans for combatting the opiate epidemic. Utilize available statistics and information to better inform local officials about the scope of the opiate crisis in your county or region.
- 2) Familiarize yourself with the terms of Drug MediCal’s Organized Delivery System waiver, which eliminates the impact of the IMD exclusion and expands treatment availability. Work with your state officials to pursue your own state’s 1115 Medicaid waiver based on California’s innovative model, recognizing that this waiver can substantially improve opiate treatment availability for individuals outside the criminal justice system.
- 3) Join NACBHDD and NACo in advocating for nationwide policy changes that extend the reach of opiate addiction treatment into the criminal justice system by creating a “narrow” waiver to the Medicaid inmate exclusion in your state’s 1115 waiver plans. Begin by reading the paper titled “Addressing the Disparate Impact of the Federal Response to the Opiate Epidemic,” by Daniel Mistak, General Counsel for Community Oriented Correctional Health Services (COCHS) (Paper is attached to this e-mail). Then, advocate for an inmate exclusion waiver in your state’s 1115 Medicaid waiver that enables the state or its counties to use Medicaid Federal Financial Participation (FFP) dollars:
  - To work with Medicaid providers to both identify patients in county jails who are receiving community-based opiate treatment and to maintain their treatment protocols.
  - For Medicaid providers to work with county jails to develop opioid treatment and continuity of care plans for released or diverted individuals subject to the ASAM criteria.

- To initiate MAT or other forms of medically necessary and appropriate intervention for jailed individuals with opiate addiction whose release is anticipated within 7-10 days.

*Researched and Written by Dennis Grantham*

**COMPARING HR 2646 (REPS. MURPHY/JOHNSON) AND S 1945 (SENS. CASSIDY/MURPHY)** Agenda Item 4B

TOPIC	<p align="center"><b>HR 2646</b> <i>Helping Families in Mental Health Crisis Act</i> <b>(MURPHY/JOHNSON)</b></p>	<p align="center"><b>S 1945</b> <i>Mental Health Reform Act of 2015</i> <b>(CASSIDY/MURPHY)</b></p>	<p align="center"><b>NACBHDD</b> <b>POSITION</b></p>
<i>Assistant Secretary for Mental Health and Substance Use Disorder (OAS))</i>	<ul style="list-style-type: none"> <li>Establishes an Assistant Secretary (AS) for Mental Health and Substance Use Disorders (a board certified psychiatrist or a psychologist with clinical and research expertise, including knowledge of biological, psychosocial and pharmacological issues in treatment).</li> <li>The AS, who heads the Office of the Assistant Secretary for Mental Health and Substance Use Disorders (OAS), is appointed by HHS Secretary, subject to Senate confirmation, and reports to the HHS Secretary. [Sec. 101]</li> </ul>	<ul style="list-style-type: none"> <li>Establishes an Assistant Secretary (AS) for Mental Health and Substance Use Disorders (a board certified psychiatrist, a psychologist, or a social worker with clinical and research expertise).</li> <li>The AS who heads the Office of the Assistant Secretary for Mental Health and Substance Use Disorders (OAS), is named by the President, subject to Senate confirmation, and reports to the HHS Secretary. [Sec. 101(a)]</li> </ul>	<ul style="list-style-type: none"> <li>NACBHDD opposes the language in both bills.</li> <li>NACBHDD supports a White House Office of National Mental Health Policy.</li> </ul>
<i>SAMHSA Status in Law</i>	<ul style="list-style-type: none"> <li>Within 6 months of enactment, transfers to the OAS all SAMHSA assets, personnel and obligations, as well as all of SAMHSA’s legislative authorities not otherwise terminated under the Act. A Deputy AS may be appointed by the AS, with HHS Secretary’s approval. [Sec.102].</li> </ul>	<ul style="list-style-type: none"> <li>SAMHSA Administrator reports to the AS; Agency continues as an independent agency of HHS. [Sec. 101(b)]</li> </ul>	<ul style="list-style-type: none"> <li>NACBHDD opposes the language in both bills.</li> <li>NACBHDD supports SAMHSA as an independent agency of HHS, reporting to the Secretary.</li> </ul>
<i>Role of OAS</i>	<ul style="list-style-type: none"> <li>OAS promotes, evaluates, organizes, integrates, and coordinates research, treatment, and services across departments, agencies, organizations and individuals with respect to the problems of individuals with substance use disorders or mental illness. [Sec. 101(b)(1)]</li> <li>Lead on promoting and improving research, and treatment &amp; services for those with behavioral disorders, including all programs related to prevention, treatment and recovery from MI or SUD.</li> <li>Charged to:               <ul style="list-style-type: none"> <li>End duplicative, non-evidence-based or ineffective programs, by coordinating, merging or eliminating them.</li> <li>Make or renew grants for services, treatment and secondary/tertiary prevention only if evidence-based and known effective or, if new, that comport with scientific standards and likely to be effective.</li> <li>Implement programs of workforce development for diagnosing and treating people with SMI, particularly in underserved areas</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>OAS promotes, evaluates, organizes, integrates, and coordinates research, treatment, and services across departments, agencies, organizations, and individuals with respect to the problems of individuals with substance use disorders or mental illness. [Sec. 101(c)]</li> <li>Improve access to and provision of evidence-based prevention, intervention, treatment and rehabilitation services for people with behavioral disorders.</li> <li>Ensure grants made are evidence-based, have scientific merit and are non-duplicative.</li> <li>Promote workforce development.</li> <li>Develop criteria for implementation and dissemination of evidence-based best practices developed by the NMHPL.</li> <li>Identify duplicative, non-evidence-based or ineffective programs, and coordinate or merge them into existing successful programs.</li> <li>Implement workforce development programs for diagnosing/treating people in underserved areas</li> </ul>	<ul style="list-style-type: none"> <li>NACBHDD opposes the language in both bills</li> <li>NACBHDD supports placement of all policy and coordinative functions in a White House Office of National Mental Health Policy.</li> <li>Program functions remain within SAMHSA</li> </ul>

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	<b><i>Helping Families in Mental Health Crisis Act</i></b>	<b><i>Mental Health Reform Act of 2015</i></b>	<b><i>NACBHDD Position</i></b>
<i>Role of OAS (cont'd)</i>	<ul style="list-style-type: none"> <li>• Undertake communications, fiscal, and planning functions for discretionary and other grant programs, including MI and SA block grant programs.</li> <li>• Manage Interagency Serious Mental Illness Coordinating Committee and supervise National Mental Health Policy Laboratory. [Sec. 101(b)(2-8)]</li> </ul>	<ul style="list-style-type: none"> <li>• Identify ways to relieve the strain on the budgets of the judicial and criminal justice systems related to serving people with behavioral disorders.</li> </ul>	
<i>OAS Priority Issues</i>	<ul style="list-style-type: none"> <li>• Integrated care (including in justice system).</li> <li>• Crisis intervention for early diagnosis/treatment.</li> <li>• Workforce development for future researchers and clinicians using evidence-based practices. [Sec. 101(d)]</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated care (including in the justice system).</li> <li>• Early diagnosis and intervention services to prevent, treat and rehabilitate SMI or SUD.</li> <li>• Parity of coverage for behavioral health.</li> <li>• Homelessness and criminal justice issues.</li> <li>• Workforce development for future researchers and clinicians using evidence-based practices (<i>includes peer support specialists</i>). [Secs. 101(c)(3) and 101(e)]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD opposes the priority language in both bills because of the placement in an OAS.</li> <li>• NACBHDD supports these priority issues and their placement within a White House Office of National Mental Health Policy.</li> <li>• NACBHDD supports placement of programs and funding for these priorities within SAMHSA as an independent agency of HHS, reporting to the Secretary.</li> </ul>
<i>Grant Authority, Restrictions and Limits</i>	<ul style="list-style-type: none"> <li>• Any grants or other awards must relate to or be based on applied research; be or be likely to be effective; use evidence-based practices; be made based on blind, peer-review process. [Sec. 101(e)]</li> </ul>	<ul style="list-style-type: none"> <li>• OAS is to ensure that all grants, with respect to serious mental illness or substance use disorders, are consistent with the grant management standards set forth by the Department, and that such grants are evidence-based, have scientific merit and avoid duplication. [Sec. 101(c)(2)(C)]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD supports the language in both bills, and recognizes the importance of quality research and appropriate grant management standards.</li> <li>• NACBHDD believes SAMHSA should remain the grant-giving agency and ensure that these standards are met.</li> </ul>

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	<b><i>Helping Families in Mental Health Crisis Act</i></b>	<b><i>Mental Health Reform Act of 2015</i></b>	<b><i>NACBHDD Position</i></b>
<i>National Mental Health Policy Lab</i>	<ul style="list-style-type: none"> <li>• A National Mental Health Policy Lab (NMHPL), in the OAS, will evaluate and disseminate best practice models; and set and publicly disseminate standards for grant programs and grants administered by the OAS and for data collected by grantees, including States. Composition percentages of NMHP are specified. [Sec. 201].</li> </ul>	<ul style="list-style-type: none"> <li>• A National Mental Health Policy Lab (NMHPL), in the OAS, will evaluate trends and both implement and monitor policy change affecting mental health services by collecting grant information, including state block grant programs; will disseminate best practices and service delivery models. Preference will be for models focused on: integrated care; coordination among providers including justice and criminal systems; programs for people with SMI; practices and programs recognizing the role of family participation in recovery. [Sec. 201]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD opposes the language in both bills because of the placement in the OAS.</li> <li>• NACBHDD supports the creation of a National Mental Health Policy Lab within the White House Office of National Mental Health Policy.</li> </ul>
<i>Grant Reform and Restructuring-Discretionary Grants</i>	<ul style="list-style-type: none"> <li>• OAS discretionary grants for primary prevention, screening, diagnosis, treatment or services, can be awarded to state/local governments, academia and nonprofits:                             <ul style="list-style-type: none"> <li>• <i>Innovation Grants</i> to expand promising models. [Sec. 202]</li> <li>• <i>Demonstration Grants</i> to bring evidence-based practices related to applied delivery of care and/or integrating models across jurisdictions and specialties to broader scale. At least half must be for populations under age 26. [Sec. 203]</li> </ul> </li> <li>• NMHPL may award grants for early childhood intervention and treatment (ages 0-12) and for longitudinal outcome studies of the funded programs. [Section 204]</li> </ul>	<ul style="list-style-type: none"> <li>• OAS discretionary grants for primary prevention, screening, diagnosis, treatment or services, can be awarded to state/local government, academia and nonprofits:                             <ul style="list-style-type: none"> <li>• <i>Innovation Grants</i> to expand promising models, including for integrated care, with no more than 1/3 for prevention, no less than 1/3 for screening, diagnosis, treatment and services for those under age 18. {Sec. 202}</li> <li>• <i>Demonstration Grants</i> to bring evidence-based practices related to applied delivery of care and/or integrating models across jurisdictions and specialties to broader scale. At least half must be for populations under age 26. [Sec. 203]</li> </ul> </li> <li>• NMHPL may award grants for early childhood intervention and treatment (ages 3-12) and for longitudinal outcome studies of the funded programs. [Sec. 204]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD opposes the language in both bills because of the authority extended to OAS and the NMHPL for grant-making.</li> <li>• NACBHDD supports placement of these grant-making functions within SAMHSA as an independent HHS agency, reporting to the Secretary.</li> <li>• NACBHDD questions the age ranges for children in both bills because of the potential for labeling.</li> </ul>
<i>Grant Reform and Restructuring-Assisted Outpatient Treatment</i>	<ul style="list-style-type: none"> <li>• AOT grant program for people with SMI is extended through 2020, with 20% of funds for existing AOT programs; 80% for new AOT programs. [Sec. 205]</li> </ul>	<ul style="list-style-type: none"> <li>• AOT grant program for people with SMI is extended through 2020. [Sec. 205]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD opposes the language in both bills.</li> <li>• NACBHDD supports alternatives to AOT, including, but not limited to, advanced psychiatric directives, medical powers of attorney, and self- and peer-referral to treatment.</li> </ul>

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	<b><i>Helping Families in Mental Health Crisis Act</i></b>	<b><i>Mental Health Reform Act of 2015</i></b>	<b><i>NACBHDD Position</i></b>
<b><i>Grant Reform and Restructuring-Block Grants</i></b>	<p>Block Grants. [Sec. 206]</p> <ul style="list-style-type: none"> <li>• 5% of funds to NIMH for translating best practices in research to systems of care (e.g., RAISE program).</li> <li>• Requires integrated physical and mental health services.</li> <li>• For funding, a state must have a law allowing judges to <i>require</i> an individual to receive outpatient treatment. Further, states providing AOT for individuals found to be a danger to self/other or “unable to accept voluntary treatment” get a 2% increase in their block grant funds. [Sec. 206(e) and Sec. 206(f)]</li> <li>• Use of new best practices may be required by regulation, subject to Congressional approval. [Sec. 206(g)(2)]</li> <li>• <i>Active outreach and engagement of those with SMI</i>—including AOT—is required as a condition of a block grant. [Section 206(e)]</li> </ul>	<p>Block Grants [Sec. 206] are reauthorized through 2019—</p> <ul style="list-style-type: none"> <li>• 5% obligated for translating best practices in research to systems of care.</li> <li>• Requires integrated physical and behavioral health services.</li> <li>• Provides incentives for state-based outcome measures (2% of state’s block grant funds).</li> <li>• New best practices may be added by regulation, as long as they would improve care and outcomes.</li> <li>• Active outreach and engagement of those with SMI are to be part of state plan activities, focusing on individuals who are homeless, have co-occurring disorders, who have a history of treatment failure or who are at risk for incarceration/reincarceration.</li> <li>• SAMHSA and NIMH to develop list of effective assertive outreach and engagement programs—with a list of possible types of program noted in the legislation.</li> <li>• Promotes development of Advanced Psychiatric Directives.</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD opposes much of the language in the House bill including the transfer of 5% of funds to NIMH and the AOT requirements.</li> <li>• NACBHDD supports the language in the Senate version of the bill.</li> </ul>
<b><i>Grant Reform and Restructuring-Telepsychiatry</i></b>	<ul style="list-style-type: none"> <li>• <i>Workforce Development and Telepsychiatry</i> grant program for States to train (and then pay for services by) primary care physicians in behavioral health screening (including for suicide and violence), and in the use of telepsychiatry consultations. [Sec. 207(a)]</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes HRSA to make Telehealth Child Psychiatric Access Grants to states and tribal entities to promote behavioral health integration in pediatric primary care (has a 20% match requirement). [Sec. 207]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD supports the telepsychiatry grant program language in both bills</li> </ul>
<b><i>Grant Reform and Restructuring-Existing Programs</i></b>	<ul style="list-style-type: none"> <li>• The Minority Fellowship program continues under the OAS. [Sec. 207(c)]</li> <li>• Pediatric psychiatry specialists are added to the NHSC; children and adolescents are made a shortage population. [Sec. 207(d)]</li> <li>• Grants program to better train law enforcement to work with people with SMI/SUD. [Sec. 207(e)]</li> <li>• <i>Authorized Grant programs</i> [Sec. 208]:</li> <li>• Children’s recovery from trauma [NCTSI] [Sec. 208(a)]</li> <li>• Reducing MH Stigma campaign by Department of Education and OAS .[Sec. 208(b)]</li> </ul>	<ul style="list-style-type: none"> <li>• The Minority Fellowship program is continued through the OAS. [Sec 208] Minority Fellowship program is continued through 2021.[Sec. 209]</li> <li>• Pediatric psychiatry specialists are added to the NHSC with service payback; children and adolescents are made a shortage population. [Sec.210]</li> <li>• Reauthorizes mental/behavioral health education and training grants through SAMHSA/HRSA to support workforce with emphasis on children/youth and “transitional youth” (ages 16-26). [Sec. 211]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD opposes making grants through OAS rather than through SAMHSA as an independent agency of HHS, reporting to the Secretary.</li> <li>• NACBHDD supports the continuation of the identified programs.</li> </ul>

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	<b><i>Helping Families in Mental Health Crisis Act</i></b>	<b><i>Mental Health Reform Act of 2015</i></b>	<b><i>NACBHDD Position</i></b>
<i>Grant Reform and Restructuring-Existing Programs, Cont'd.</i>	<ul style="list-style-type: none"> <li>Garrett Lee Smith (Suicide Prevention) Act TA center continuation and state/tribal grants for youth suicide early intervention and prevention programs, of which 85% of funding must be used for direct services. Campus suicide prevention program continued with 1 for 1 matching requirement. Suicide prevention lifeline continued. [Sec. 208(c)]</li> </ul>	<ul style="list-style-type: none"> <li>Suicide prevention lifeline continued through 2020. [Sec. 212]</li> </ul>	
<i>Liability Protections</i>	<ul style="list-style-type: none"> <li>Liability protections are made for health care professional volunteers at CBHCs and CHCs. [Sec. 207(b)]</li> </ul>	<ul style="list-style-type: none"> <li>Liability protections are made for health care professional volunteers at CBHCSs and CHCs. [Sec. 208]</li> </ul>	<ul style="list-style-type: none"> <li>NACBHDD supports the language in both bills as long as liability protections match those for paid clinical staff.</li> </ul>
<i>Integration of Care</i>		<ul style="list-style-type: none"> <li>Creates primary and behavioral health care integration grant program within SAMHSA for states that is to lead to full collaboration between primary and behavioral health in an integrated practice model at a statewide level. [Sec. 301]</li> </ul>	<ul style="list-style-type: none"> <li>NACBHDD supports the language in the Senate bill.</li> </ul>
<i>Interagency SMI Coordinating Committee</i>	<ul style="list-style-type: none"> <li>The Committee's membership includes representatives from HHS agencies and Departments concerned with behavioral health issues, along with appointed non-federal members who must include at least one in recovery from SMI and one who is a family member of someone with SMI. It will develop and update a strategic plan for advancing research on, and promoting use of and compliance with treatments for people with SMIs; [Sec. 301]</li> </ul>	<ul style="list-style-type: none"> <li>The Committee will develop and update every 3 years a strategic plan for the conduct and support of programs and services to assist individuals with serious mental illness. Membership includes no more than 9 federal members and at least 14 non-federal members who must include at least one in recovery from SMI and one who is a family member of someone with SMI. [Sec. 401]</li> </ul>	<ul style="list-style-type: none"> <li>NACBHDD supports the language in both bills and recommends placement of the Coordinating Committee within the White House Office of National Mental Health Policy.</li> </ul>
<i>HIPAA/FERPA</i>	<ul style="list-style-type: none"> <li>Lifts HIPAA restrictions on caregiver access to treatment information (diagnosis, treatment plan, medications) of individuals with an SMI, age 18+, under certain circumstances [e.g., protecting health/welfare of individual/general public, diminished capacity, and other conditions). [Sec. 401(a)]</li> <li>Allows caregivers access to certain information held by institutions of higher learning under FERPA. [Sec. 402]</li> </ul>	<ul style="list-style-type: none"> <li>Clarifies HIPAA disclosure ok if agreed to by the individual whose records are in question, or if the physician believes it is in best interests of an incapacitated/absent patient. Recommends use of psychiatric advanced directives. [Sec. 501]</li> <li>Lists factors which a healthcare professional should consider when assessing a patient's "best interests" (e.g., housing, timely intervention, increased living skills). [Sec. 502]</li> <li>Requires creation (within 1 year of enactment) of a model program and training materials on when HIPAA materials may be disclosed without patient consent. [Se. 503]</li> </ul>	<ul style="list-style-type: none"> <li>NACBHDD opposes the language in the House bill.</li> <li>NACBHDD supports the language in the Senate bill. The rationale provided in the Senate bill sets appropriate parameters on disclosure.</li> </ul>

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<i>HIPAA/FERPA, Cont'd.</i>		<ul style="list-style-type: none"> <li>• Provides for streamlined consent in integrated care settings. [Sec. 504]</li> </ul>	
<i>Medicaid Reform</i>	<ul style="list-style-type: none"> <li>• Allows Medicaid payment for same-day MH and physical health care services at a CMHC or FQCHC. [Sec. 501(a)]</li> <li>• Medicaid IMD exception can be lifted at State's option to provide inpatient psychiatric services for people between 21-64 (including acute care units of state hospitals and RTCs with less than 30 day average stays), BUT requires fiscal and outcome reports. <i>Requires CMS to certify that these services do not increase Medicaid costs.</i> [Sec. 501(b)(1)]</li> <li>• States cannot exclude MH medications previously approved. MCOs must provide all covered psychiatric meds when contracting with Medicaid. [Sec. 501(b)(2)]</li> </ul>	<ul style="list-style-type: none"> <li>• Allows Medicaid payment for same-day MH and physical health care services at a CMHC or FQCHC. [Sec. 601(a)]</li> <li>• Medicaid IMD exception can be lifted at State's option to provide inpatient psychiatric services for people between 21-64 (including acute care units of state and other psychiatric hospitals with less than 20 day average stays). <i>Requires CMS to certify that these services do not increase Medicaid costs.</i> [Sec. 602(b)]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD opposes the requirement that the CMS certify that provision is budget neutral.</li> <li>• NACBHDD supports the other provisions in the Senate language, particularly because it does not encourage lengthy hospitalization or rehospitalization.</li> </ul>
<i>Medicaid Grant Program</i>	<ul style="list-style-type: none"> <li>• Grant program for 10-state/4 year demonstrations of certified CBHCs to improve community mental health services, including AOT, for Medicaid-eligible people with MI, utilizing prospective payment systems. Detailed outcome reports required. [Sec. 505]</li> </ul>		<ul style="list-style-type: none"> <li>• NACBHDD supports the House bill's Medicaid demonstration grant program, but opposes inclusion of AOT as a required component of the grant program.</li> </ul>
<i>Medicare Reform</i>	<ul style="list-style-type: none"> <li>• Eliminates 190 day lifetime limit for inpatient psychiatric hospitalizations <i>unless</i> CMS actuary finds that it increases Medicare costs. [Sec. 503] Mandates discharge planning regulations (standards) required.</li> </ul>	<ul style="list-style-type: none"> <li>• HHS to codify guidelines and standards as regulations for discharge planning for those leaving a psychiatric facility or unit for post-hospital or rehabilitative care within 24 months after enactment. [Sec. 602]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD concurs in the language in the Senate and House bills, as both are consistent with MHPAEA and the known value of discharge planning.</li> </ul>
<i>NIMH Research</i>	<ul style="list-style-type: none"> <li>• Increases NIMH brain initiative research funds related to determinants of self- or other-directed violence. [Sec. 601]</li> </ul>	<ul style="list-style-type: none"> <li>• Increases NIMH brain initiative research funds related to determinants of self- or other-directed violence. [Sec. 701]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD supports the language in both the Senate and House bills.</li> </ul>
<i>Behavioral Health Information Technology</i>	<ul style="list-style-type: none"> <li>• Extends Medicare and Medicaid HIT assistance for behavioral health programs providers (CBHCs, psychiatrists, psychologists, and both inpatient and facilities, etc.). [Sec. 701]</li> </ul>		<ul style="list-style-type: none"> <li>• NACBHDD supports the language in the House bill, consistent with prior NACBHDD HIT policy.</li> </ul>

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<i>SAMHSA Reforms</i>	<ul style="list-style-type: none"> <li>• Medicalizes peer review committees, with at least half MDs or psychologists; Congressional committees informed before grants/contract made. [Sec. 801]</li> <li>• Restructures membership of Advisory Committees. [Sec. 802]</li> </ul>	<ul style="list-style-type: none"> <li>• Medicalizes peer review committees, with at least half MDs or psychologists; Congressional committees informed before grants/contract made. [Sec. 801]</li> <li>• Similarly restructures membership of Advisory Committees. [Sec 802]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD supports the inclusion of medical professionals on peer review/advisory committees but not to the exclusion of peer, provider and caregiver viewpoints.</li> </ul>
<i>SAMHSA Reauthorization</i>		<ul style="list-style-type: none"> <li>• <i>Reauthorizes/authorizes through 2021:</i> <ul style="list-style-type: none"> <li>• Jail Diversion grant program. [Sec. 803]</li> <li>• PATH program. [Sec. 804]</li> <li>• Comprehensive Children’s Program. [Sec. 805]</li> <li>• Programs of Regional/National Significance. [Sec. 806]</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD supports the language in the Senate bill</li> </ul>
<i>PAIMI</i>	<ul style="list-style-type: none"> <li>• PAIMI systems prohibited from lobbying; caregivers given access to protected patient information; PAIMI efforts limited solely to protecting against “abuse and neglect” and assure individuals with SMI get evidence-based treatment; establishes a grievance process. [Sec. 811-816]</li> </ul>		<ul style="list-style-type: none"> <li>• NCBHDD opposes the language in the House bill and supports the current PAIMI program within SAMHSA as an independent HHS agency, reporting to the Secretary.</li> </ul>
<i>Parity</i>		<ul style="list-style-type: none"> <li>• To strengthen parity compliance, HHS and DoL will issue guidance to help insurers satisfy parity act requirements and how to collect relevant data and share it with HHS. [Section 903]</li> <li>• Requires health plans to clarify processes/timelines for filing parity-related coverage/service complaints. [Section 903]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD supports the language in the Senate bill</li> </ul>
<i>Reports and Investigations</i>	<ul style="list-style-type: none"> <li>• <i>National workforce strategy</i> report due to Congress within 1 year of enactment. Note: this includes peer-support specialists). {Sec. 101(b)(9)}</li> <li>• Detailed report by CMS and other relevant agencies and offices on <i>parity investigations</i> ongoing in past 12 months, submitted to Congress within 180 days of enactment and annually thereafter. [Sec. 103(a)]</li> <li>• Detailed report to Congress on <i>best practices for peer-support</i> specialist programs, training and certification criteria, due within 1 year of enactment, and every 2 years thereafter. [Sec. 103(b)]</li> </ul>	<ul style="list-style-type: none"> <li>• <i>National workforce strategy</i> report due to Congress within 18 months of enactment and every 2 years thereafter, detailing plans to recruit, train and increase the mental health workforce to treat individuals with mental illness, SMI, SUD and co-occurring disorders. [Sec. 101(d)]</li> <li>• Report to Congress on <i>best practices for peer-support</i> specialists program, training and certification due within 18 months of enactment and every 2 years thereafter. [Sec. 102(a)]</li> </ul>	<ul style="list-style-type: none"> <li>• NACBHDD supports the concepts underlying all of the reports in both the Senate and House bills, with HHS leadership on the reports vested in SAMHSA, with appropriate input from the White House Office of National Mental Health Policy.</li> </ul>

	<b><i>Helping Families in Mental Health Crisis Act</i></b>	<b><i>Mental Health Reform Act of 2015</i></b>	<b><i>NACBDD Position</i></b>
<i>Reports, Cont'd.</i>	<ul style="list-style-type: none"> <li>• <i>State of States</i> report on how federal behavioral health funds are being used by states; use of best practices; data on health outcomes, <i>including use of AOT</i>, due within 1 year of enactment and every 2 years thereafter. [Sec. 103(c)]</li> <li>• Report by IOM or other entity that assesses <i>paperwork burden of regulations</i> for CMHCs and makes recommendations for reducing the [<i>seemingly assumed</i>] burden. [Sec. 103(d)]</li> <li>• Through the NMHPL, produce a <i>quality of care report</i> to Congress on AS-funded service grant programs, including patient and public health outcomes within 1 year of enactment and every 2 years thereafter. [Sec. 201(d)]</li> <li>• OAS to submit annual report to Congress on effectiveness of telepsychiatry and primary provider training grants and another report by the end of 2018 with recommendations on expansion to the national level. [Sec. 207(a)(10)(A) and (B)]</li> <li>• Report by <i>Interagency SMI Coordinating Committee</i> to Congress on the cost, effectiveness, quality and coordination of Federal activities on prevention, treatment and rehabilitation for SMI and SUD, due within 1 year of enactment and every 2 years thereafter. [Section 301(d)]</li> <li>• GAO study on <i>Preventing discriminatory coverage limitations for people with SMIs and SUDs</i>. outlining how covered health plans (including those under the ACA) are complying with parity requirements, due within 1 year of enactment. [Section 901]</li> </ul>	<ul style="list-style-type: none"> <li>• <i>State of States</i> report on how federal behavioral health funds are being used by states; use of best practices; data on health outcomes, <i>including use of different outpatient treatment models for people with SMI that are court ordered or voluntary</i>. [Sec. 102(b)]</li> <li>• Report by IOM or other entity that assesses <i>paperwork burden of regulations</i> for CMHCs and makes recommendations for reducing the [<i>seemingly assumed</i>] burden. [Sec. 103(d)]</li> <li>• Through the NMHPL, produce a <i>quality of care report</i> to Congress on AS-funded service grant programs, including patient and public health outcomes within 2 years of enactment and every 2 years thereafter. [Sec. 201(d)]</li> <li>• SAMHSA/HRSA report on effectiveness of workforce promotion programs, including related to integrated care, undertaken under this measure, within 2 years of enactment and every year thereafter. [Sec. 211(e)]</li> <li>• Report by <i>Interagency SMI Coordinating Committee</i> to Congress on the cost, effectiveness, quality and coordination of Federal activities to prevent, treat and rehabilitate for SMI and SUD, due within 1 year after release of first Strategic Plan, and annually thereafter. [Section 301(d)]</li> <li>• Study by HHS for Congress within 2 years of enactment on the impact of the changes made to the Medicaid IMD exclusion. [Sec. 601]</li> <li>• GAO study on <i>Preventing discriminatory coverage limitations for people with SMIs and SUDs</i>. outlining how covered health plans (including those under the ACA) are complying with parity requirements, due within 1 year of enactment. [Sec. 901]</li> <li>• CMS, DoL, and others provide a report to Congress on behavioral health care parity investigations, within 1 year of enactment. [Sec. 902]</li> </ul>	

