NASMHPD Annual Conference

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NASMPHD Government Affairs: What Do We Do?

NASMPHD Government Affairs: What Do We Do?

1. Engage with SAMSHA and CMS officials in ongoing policy discussions (HCBS transition plans and isolating sites)

2. Engage with Congressional members and staff on draft legislative proposals, proposed amendments (Senator Rob Portman's (R-OH) IMD bill amendment mandating state maintenance of inpatient mental health and substance use beds as a condition for Medicaid reimbursement for IMD treatment of substance use disorders)

3. Brief Congressional budget staff on mental health and substance abuse issues (42 CFR Part 2)

4. Help prepare the Executive Director and NASMHPD members to testify before Congress if called.

NASMPHD Government Affairs:
What Do We Do?

4. Participate in and attend formal Congressional staff briefings
5. Review & analyze Congressional legislation, collect NASMHPD member feedback, and draft support or opposition letters or suggest amendments
6. Review & analyze proposed regulations, notices, grant opportunities from SAMHSA, CMS (Medicaid, Medicare, CHIP), NIH, ACF, etc.
7. Notify NASMHPD members of legislative activity, agency policy initiatives, RFPs, grant opportunities, that might impact them.

NASMPHD Government Affairs:
What Do We Do?

- Partner with other public official associations, stakeholders in advocacy
  - with **Medicaid Directors**, **National Council** on mental health parity regulations,
  - with **Mental Health Liaison Group** and **Children's Mental Health Coalition** on CHIP reauthorization & extension, SAMHSA funding issues, Medicaid per-capita cap block grants
  - with **National Association of Counties, Council of State Governments** on criminal justice diversion initiatives, programs
  - with **42 CFR Part 2 Partnership** on aligning 42 CFR Part 2 disclosure restrictions with HIPAA restrictions under H.R. 6082 (which has passed the House)

NASMPHD Government Affairs:
What Do We Do?

8. Work with Stakeholder Coalitions in developing industry-wide policy positions:

- **Mental Health Liaison Group (MHLG):** National Council, NAMI, both APAs, Bazelon, NASADAD, MHA, NAADAC, ASAM, et al.
- **Coalition for Whole Health (CWH):** jointly led by National Association of County Behavioral Health & Developmental Disability Directors & Legal Action Center
- **Children's Mental Health Coalition** on CHIP, children's mental health funding, outreach to SAMHSA
- **42 CFR Partnership** on language of the 42 CFR Part 2 legislation and any amendments offered by members of Congress

NASMHPD Comments on Medicare Psychiatric Hospital Payment Rules

- CMS proposed eliminating the following quality measures for psychiatric inpatient facilities for the Medicare program in FY 2019:
  - Alcohol Use Screening;
  - Tobacco Use Screening;
  - Hours of Physical Restraint Use;
  - Hours of Seclusion Use; and
  - Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use
- CMS said the measures had either "topped out," with the majority of participants scoring high, did not justify the administrative burden to participants or the agency, or were duplicative of other existing measures.
- With regard to the seclusion and restraint measures, CMS noted the Joint Commission enforces compliance.
- CMS said the tobacco use treatment at discharge measure is already covered by other transitions measures.

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NASMHPD Comments on Medicare Psychiatric Hospital Payment Rules (cont'd)

- NASMHPD filed comments opposing elimination of the restraints and seclusion measures for psychiatric inpatient hospitals, saying that, while NASMHPD members appreciate the Administration's efforts to relieve providers of unnecessary administrative compliance burden under the Medicaid and Medicare programs, compliance with restraint and seclusion standards remains far from universal even though quality measures reporting is high and despite the Centers for Medicare and Medicaid Services' delegation to the Joint Commission of enforcement of those standards.
- NASMHPD said that requiring quality measures reporting on restraints and seclusion serves an admonitory purpose that supplements the threat of Joint Commission enforcement action by affirmatively reminding administrators of psychiatric inpatient facilities of their responsibilities regarding the standards.
- NASMHPD signed onto a separate coalition letter opposing the elimination of the Medicare tobacco cessation measures.

NASMHPD Offers Amendment on Medicare HIPPS GME

- Finally, NASMHPD filed a comment letter drafted by the Medical Directors' Council recommending that the FY 2019 Medicare Hospital Inpatient Prospective Payment regulations be amended to permit hospitals with new or established graduate medical education (GME) programs in areas of need to apply for additional GME residency slots through a Cap Flexibility demonstration project.
- The letter asked that slots be prioritized for hospitals supplying psychiatric residency training to regions with a shortage of physicians that provide mental health care and treatment.

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House Appropriations Approves FY 2019 Funding for SAMHSA at FY 2018 Levels

- The House Appropriations Committee was to mark up the last week of June released June 14, which includes money for SAMHSA and CMS, but the hearing was postponed to avoid Democratic amendments regarding immigration policies and procedures affecting HHS.
- The House Appropriations Committee instead finally approved a Labor-HHS funding measure July 11:
  - A total of $722,571,000 for the **Mental Health Block Grant**, which is the same as the Fiscal Year 2018 enacted program level and $160,000,000 above the Fiscal Year 2019 Trump Administration budget request program level.
  - A total of $2,358,079,000 for the **Substance Abuse Prevention and Treatment Block Grant**, which is $500,000,000 more than the Fiscal Year 2018 enacted program level and the Fiscal Year 2019 budget request program level.
- The Committee also approved $23,755,000 for **Victims of Trafficking**, the FY 2018 level and $3 million less than approved by the Senate.

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House Appropriations Approves FY 2019 Funding for SAMHSA at FY 2018 Levels

- The House funding measure also included:
  - $53,887,000 for the **National Child Traumatic Stress Initiative**, which is the same as the Fiscal Year 2018 enacted level and $5,000,000 above the Fiscal Year 2019 budget request.
  - $125,000,000 for the **Children's Mental Health program**, which is the same as the Fiscal Year 2018 enacted level and $5,974,000 above the Fiscal Year 2019 budget request. The 10 percent set-aside for prodromal interventions, passed last year, continues to be included.
  - $64,635,000 for the **Projects for Assistance in Transition from Homelessness (PATH) program**, which is the same as the Fiscal Year 2018 enacted level and the Fiscal Year 2019 budget request.

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House Appropriations Includes Language on Children at the Border

Vote in House Appropriations Committee was delayed two weeks to avoid Democratic amendments on the separation of children from their families at the border. But when the bill was finally voted, members of both parties (but mostly Democrats) offered amendments addressing the treatment and separation from families of children at the border. All Democratic amendments were adopted by voice vote.

- Rep. Katherine Clark (D-MA) offered amendments:
  - requiring a report on the mental health of separated children
  - prohibiting the administration of medication to unaccompanied alien children unless certain conditions deem such medication medically necessary
  - prohibiting funding for HHS to use questions of religion in the process of family reunification
  - requiring a report to Congress on pre-literate unaccompanied alien children

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House Appropriations Includes Language on Children at the Border (cont'd)

- Rep. Rosa DeLauro (D-CT) offered amendments:
  - directing $10 million to fund mental health services for children separated from their families at the border.
  - requiring HHS to submit a plan to reunify immigrant children with their parents
- Rep. Debbie Wasserman Schultz (D-FL) offered an amendment requiring an Inspector General report on family separation and reunification policies.
- Rep. Chellie Pingree (D-ME) offered an amendment supporting efforts to house immigrant children who are siblings together
- Rep. Mark Pocan (D-WI) offered an amendment expressing a sense of Congress regarding family separations and the reunification of immigrant families.

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House Appropriations Includes Language on Children at the Border (cont'd)

- Rep. Marci Kaptur (D-OH) offered an amendment protecting the privacy of personal and genetic information of children and adults if used in the process of family reunification.
- Health Subcommittee Chair Tom Cole (R-OK) offered an amendment clarifying that immigrant families, if detained, must be detained as a unit. The amendment was adopted on a roll call vote of 31-21.

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House & Senate Appropriations Both Set up New ACE Study by Surgeon General, with Help from SAMHSA, CDC, NIH, and ACF

- The House measure *directs* the Surgeon General to conduct an updated study of adverse childhood experiences (ACEs), including substance misuse in the household, sexual abuse, and parental divorce or separation—and negative long-term health and behavioral health outcomes, including early initiation of alcohol and tobacco use, substance misuse, teen pregnancy, violence, and increased risk of suicide. The report is due to the Committees on Appropriations within 180 days. The Surgeon General is directed to work with the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), SAMHSA, and the Administration for Children and Families (ACF) on the connection between adverse childhood experience and negative long-term health outcomes, including future substance misuse.
- The Senate Appropriations Committee approved funding for Labor-HHS in S. 3158, on June 28.
- The Senate Committee Report also includes ACE report language stating: The Committee is aware that more than half of children, across all socioeconomic groups, experience an ACE such as physical abuse, substance misuse in the household, sexual abuse, and parental divorce, or separation. The Committee *encourages* the Office of the Surgeon General to develop a report on the connection between ACE future substance misuse, and other health conditions. The Surgeon General should collaborate with CDC, NIH, SAMHSA, and ACF.

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Senate Appropriations Committee Also Urges Trauma Surveillance by CDC

- The Senate Committee in its Committee Report commends the CDC for providing funding to States to conduct surveillance on youth and adult behavioral risk factors. The Committee encourages CDC to prioritize collection and reporting of data on adverse childhood experiences, including exposure to violence. The Committee also encourages CDC to report on the prevalence of adverse childhood experiences across geography, race and ethnicity, and socioeconomic status.
- **Children's Mental Health –** The Senate Committee appropriated $125,000,000 for the Children's Mental Health program, which is the same as the Fiscal Year 2018 enacted level (and the same as the House) and $5,974,000 above the Fiscal Year 2019 budget request. The 10 percent set-aside for prodromal interventions was included.
- **Child Traumatic Stress Network.**—The Senate Committee included an additional $2 million over FY 2018 levels (and what the House provides), to bring the total to $56,887,000.

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Senate Appropriations Approves Labor-HHS Funding

The Senate funding measure also includes:

- **Mental Health** – $1.6 billion, $79 million above FY2018, for mental health programs at SAMHSA.
  - Within this total, the bill provides $748 million for the Mental Health Block Grant, an increase of $25 million over FY 2018 and $25 million more than the House Bill.
- **Substance Use Block Grant -** The Senate Appropriations Committee approved $3,812,006,000 for substance abuse treatment programs, including $1,858,079,000 for the substance abuse prevention and treatment block grant to the States ($500,000 less than the House, but funding at FY 2018 levels).

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Senate Appropriations Approves Labor-HHS Funding (cont'd)

- **Opioid Funding** - The Committee provides $1.5 billion for grants to States to address the opioid crisis.
  - Bill language continues to provide $50,000,000 for grants to Indian Tribes or Tribal organizations and a 15 percent set-aside for States with the highest age-adjusted mortality rate related to opioid overdose deaths.
  - Activities funded with this grant may include bona fide treatment, prevention, and recovery support services. States receiving these grants should ensure that comprehensive, effective, universal prevention strategies to stop the misuse of opioids before it starts are a priority use for the funds.

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Senate Appropriations Approves Labor-HHS Funding (cont'd)

- **Suicide Prevention programs –** The Senate Committee funds suicide prevention programs, including the Suicide Lifeline, at FY 2018 levels:
  - National Strategy for Suicide Prevention 11,000
  - Suicide Lifeline 7,198
  - GLS—Youth Suicide Prevention—States 35,427
  - GLS—Youth Suicide Prevention—Campus 6,488
  - AI/AN Suicide Prevention Initiative 2,931
- The Committee notes that NIMH has had some encouraging breakthroughs in research on risk detection algorithms, and that such tools can be made increasingly sophisticated now with the power of big data tools. The Committee urges NIMH to prioritize its suicide prevention research efforts to produce models that are interpretable, scalable, and practical for clinical implementation, including mental and behavioral health care interventions, to combat suicide in the United States. It requests an update on NIMH efforts in this area.

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Senate Appropriations Approves Labor-HHS Funding

- **Victims of Trafficking** – The Senate Committee appropriates $27 million, $3 million above FY2018, for services for victims of human trafficking.
- **CCBHCs:** The funding measure also provides $150 million, an increase of $50 million, for new grants to Certified Community Behavioral Health Centers that meet the standards set forth in the Excellence in Mental Health and Addiction Treatment Expansion Act.
  - Note that, as they did last year, these grants go to the CCBHCs themselves, not to the states. Stay tuned for guidance.

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Senate Appropriations Approves Labor-HHS Funding

- **Rural Health Care** – The Senate Committee appropriated $318.8 million, $28 million above FY2018, for rural health programs, saying that the obstacles faced by patients and providers in rural communities are unique and often significantly different than those in urban areas. The bill focuses resources toward efforts and programs to help rural communities, including $25.5 million, $2 million above FY2018, for telehealth that can link rural health providers and patients with specialists.
- **Opioid Abuse Response in Rural Communities—**The Committee said it is aware that response to the opioid abuse crisis poses unique challenges for rural America. The Committee encourages SAMHSA to support initiatives to advance opioid abuse objectives in rural areas, specifically focusing on addressing the needs of individuals with substance use disorders in rural and medically-underserved areas, and programs that stress a comprehensive community-based approach involving academic institutions, health care providers, and local criminal justice systems.
- Within the $120 million provided for Rural Communities Opioid Abuse Response, the Senate Committee includes $20 million for the establishment of three rural Centers of Excellence on substance use disorders to support the dissemination of best practices related to the treatment for and prevention of substance use disorders within rural communities.

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Implementation of the Family First Prevention Services Act

- States had repeatedly made the case that they could reduce costs and keeps families together if they could use Federal Payments for Foster Care and Adoption Assistance (Title IV-E) for prevention services.
- One major reason kids end up in foster care is parental substance abuse (nationally more than one in three). Congress felt it could help solve the substance abuse problem and avoid child trauma at the same time.
- After three years of hearings and consideration, the Family First Prevention Services Act was passed as part of the Bipartisan Budget Act of 2018, which was signed into law on February 9, 2018 as PL 115-123.
- Responsibility over the program is vested in the Administration for Children and Families (ACF) with the Department of Health and Human Services.

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Implementation of the Family First Prevention Services Act (cont'd)

- Beginning in FY2020, Title IV-E (providing states uncapped partial matching dollars) will be available for up to 12 months for services (per family/episode) for families of children who, without services authorized under the law, would likely enter foster care, and or be pregnant or parenting foster youth. These services will include:
  - Mental health services;
  - Substance abuse services; and
  - In-home parent "skill-based" programs (parent training, home visiting, individual and family therapy).
- There will be no income-eligibility test for the assistance.

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Implementation of the Family First Prevention Services Act (cont'd)

- The FFPSA is seen as a radical remaking of the foster care program, disfavoring congregate care.
- The law provides for the following Federal contributions:
  - **Prevention Services**
    - 2020-2026: a 50 percent match for prevention services
    - 2027 & thereafter: FMAP under Medicaid
    - 2020 & thereafter: 50 percent for training and administration
  - **Kinship Navigators** (information, referral and advocacy programs for kinship caregivers)
    - 2020 & thereafter: 50 percent (states had to apply by July 20 for funds available September 30, 2018)
  - **Foster Parent Recruitment and Retention**
    - $8 million in 2018
- State Maintenance of Effort required at 2014 spending levels, with modification for smaller states with fewer than 200,000 children.

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Implementation of the Family First Prevention Services Act (cont'd)

- In an effort to eliminate congregate care, FFPSA would limit IV-E maintenance payments for foster care placements that are NOT for:
  - Family foster homes (including relatives);
  - Placements for pregnant or parenting youth;
  - Supervised independent living for youth 18+;
  - Qualified Residential Treatment Programs (QRTPs) for youth with treatment needs;
  - Specialized placements for victims of sex trafficking; or
  - Family-based residential treatment facility for substance abuse.
- Allows a state to request a delay in the effective implementation date of the provisions of Families First until 2022. States requesting a delay would postpone implementation of both the prevention and congregate care provisions of the FFPSA.

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Implementation of the Family First Prevention Services Act (cont'd)

- A QRTP:
  - has a trauma-informed treatment model and has a registered or licensed nursing and other licensed clinical staff onsite, consistent with the QRTP's treatment model;
  - facilitates outreach to the child's family members and their participation in the child's treatment program;
  - provides discharge planning and family-based aftercare supports for at least six months after the child is discharged; and
  - is licensed in accordance with the state standards for child-care institutions providing foster care and is accredited.
- Law requires states to review licensing standards to make it easier for relatives to take in children.
  - Children receiving IV-E prevention services in the home of a kin caregiver will not lose future IV-E eligibility if a federally-funded foster care placement later becomes necessary.

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Implementation of the Family First Prevention Services Act (cont'd)

- In the June 22 *Federal Register*, ACF requested recommendations, due July 22, of criteria and potential candidate programs and services for inclusion in an FFPSA-mandated Clearinghouse of evidence-based practices for mental health and substance abuse prevention and treatment programs, in-home parent skill-based programs, and kinship navigator programs appropriate for children who are candidates for foster care pregnant or parenting foster youth, and the parents or kin caregivers of those children and youth.
- Services and practices will be designated as promising, supported, or well-supported, depending on the rigor of the testing.
- The notice requested comments on potential criteria for:

  (a) identifying eligible programs and services for review by the Clearinghouse,

  (b) prioritizing eligible programs and services for review,

  (c) identifying eligible studies aligned with prioritized programs and services,

  (d) prioritizing eligible studies for rating,

  (e) rating studies, and

  (f) rating programs and services as promising, supported, and well-supported practices.

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Implementation of the Family First Prevention Services Act (cont'd)

- Gary Blau, SAMHSA's Child, Adolescent and Family Branch chief, has been meeting with Administration on Children Youth and Families Acting Commissioner Jerry Miner to discuss how SAMHSA could work with ACF to ensure the program provides evidence-based and effective mental health services.
- Blau this week urged members of NASMHPD's Children's Youth and Families Division to reach out to ACF to offer their assistance and to ask for joint guidance with ACF.
- Blau also urged NASMHPD Children's Division members to reach out to their own state's welfare agencies to help with implementation.
- NASMHPD's Children's Division will be drafting a letter to the two agencies in the next weeks, urging collaboration and seeking guidance for the states as soon as possible.

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Block-Granting Medicaid and the Exchanges

- The Heritage Foundation, Galen Institute, and the Hoover Institution are part of a Health Policy Consensus Group and that has been meeting for months to discuss yet another push to block-grant the Medicaid and Affordable Care Act Exchange programs.
- The group, led by former Pennsylvania Senator Rick Santorum, Kentucky Governor Matt Bevin, and Mississippi Governor Phil Bryant, released their proposal on June 19.
- The proposal, based largely on last year's Graham-Cassidy proposal, which failed, would:
  - convert federal funding into single grants for states to administer;
  - focus on assistance in buying into private insurance coverage, with at least 50% of the funding—including some of the funding for the low-income—earmarked for commercial insurance;
  - eliminate Obamacare's mandates including essential health benefits, single risk pools, and minimum loss ratio requirements for insurer profits;
  - do away with the 3:1 age ratio that restricts how much more older enrollees would pay compared to younger people; and
  - to determine funding allotments, peg the block grants to state spending as of a fixed date on Obamacare tax credits used to subsidize exchange coverage for the low-income, and cost-sharing reduction payments that carriers are still required by law to offer their low-income enrollees.

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Block-Granting Medicaid and the Exchanges (cont'd)

- Medicaid expansion funding would fall under the block grant but, unlike the original Graham-Cassidy bill and the GOP's previous overhaul bills, traditional Medicaid funding would not be converted to per-capita caps.
- Enrollees in the Children's Health Insurance Program could opt instead for a subsidy to buy private coverage.
- Senate Majority Leader Mitch McConnell (R-KY) has indicated a reluctance to take up yet another ACA repeal and replace measure.
  - Unlikely to be taken up before the November mid-term elections.
- *But* the House Budget Committee proposed on June 19 balancing the Federal budget in 9 years, primarily by reducing Medicaid and other health programs by $1.5 trillion, and could take the measure up.

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Trump Administration Reinstitutes Risk Adjustment Payments For Insurers in the Exchanges in 2019

- The Trump Administration on July 7 suspended $10.4 billion in risk adjustment (RA) payments due on an annual basis to insurers that cover more expensive enrollees under the Affordable Care Act.
- CMS announced the suspension was due to a February 28 decision in a Federal court in New Mexico. The agency said it had asked the court to reconsider its ruling and was awaiting a decision from a June 21 hearing.
- Congress did not specifically dictate how the program should be administered, but the Obama administration opted to run it as a budget-neutral program, i.e. spending no Federal taxpayer dollars.
- Several insurers had sued the Department of Health and Human Services, especially smaller plans and the newly created (and quickly failing) health co-ops, feeling they were disadvantaged by the approach, which calculates risk adjustment transfers based on the average statewide premium.
  - Smaller Insurers such as Molina, contend that the RA formula unduly imposes financial burdens on smaller, more financially vulnerable payers, and that larger insurers with proportionately fewer sicker enrollees benefit from the formula.

Trump Administration Suspends, Reinstitutes Risk Adjustment Payments for Insurers in 2019 (cont'd)

- In one case in Massachusetts – *Minuteman v. HHS* – the court ruled the Administration had authority to implement the RA rules as written.
- However, in a second case involving New Mexico Health Connections, the state Co-op, Federal Judge James O. Browning agreed with the plaintiffs that the rule did not properly explain the agency's reasoning for using the methodology.
- Judge Browning did not say the payment formula was illegal, but rather said the payment formula was flawed because federal officials "assumed erroneously" that collections and payments under the risk adjustment program had to offset each other so there would be no new cost to the federal government.
- Judge Browning asked that payments be suspended until the case was resolved.
- The regulatory deadline for insurers to report data impacting risk adjustment was June 30. The payments would not be due until October.

Trump Administration Suspends, Reinstitutes Risk Adjustment Payments for Insurers in 2019 (cont'd)

- America's Health Insurance Plans (AHIP) warned of market disruptions. The Blue Cross Blue Shield Association announced the choice to freeze the payments would "significantly increase 2019 premiums for millions of individuals and small business owners and could result in far fewer health plan choices"
  - And Blue Cross Blue Shield noted that the risk adjustment payments are mandatory under the ACA.
- Members of Congress were working on a legislative fix.
- CMS issued an interim final rule the evening of July 23, effective immediately, providing a fuller explanation of the methodology for calculating the RA payments and resuming those payments immediately utilizing the same method for calculating the payments.

FY 2019 Medicare Physician Fee Regulations Released

- CMS earlier this month released the 1500-page Proposed FY 2019 Medicare Physician Fee Regulations.
- The regulations will be published in the July 27 *Federal Register*, with comments due September 10.
- CMS says it is proposing a number of coding and payment changes to reduce administrative burden and improve payment accuracy for E/M visits:
  - Allowing practitioners to choose to document office/outpatient E/M visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation;
  - Allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;
  - Expanding current options regarding the documentation of history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review the previous information; and
  - Allowing practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.

FY 2019 Medicare Physician Fee Regulations Released (cont'd)

- In addition, provisions in the proposed CY 2019 Physician Fee Schedule would support access to care using telecommunications technology by:
  - paying clinicians for virtual check-ins – brief, non-face-to-face appointments via communications technology;
  - paying clinicians for evaluation of patient-submitted photos; and
  - expanding Medicare-covered telehealth services to include prolonged preventive services.
- CMS is also soliciting comment on how documentation guidelines for medical decision-making might be changed in subsequent years.
- Unanswered for future consideration: Will state Medicaid programs be urged, "encouraged" to follow suit?

Thank You

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