NASMHPD

National Association of State Mental Health Program Directors
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February 16, 2019

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
104 Hart Senate Office Bldg.
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The National Association of State Mental Health Program Directors writes in response to your letter of February 2 seeking policy recommendations on how to stem the opioid abuse epidemic using the Medicaid and Medicare programs to promote evidence-based treatment and prevention, increase utilization of non-pharmaceutical therapies for pain management, identify and educate health professionals with high opioid prescribing patterns, improve data-sharing and coordination among Medicaid, Medicare, and Prescription Drug Monitoring Programs (PDMPs), and identify what financing mechanisms need be utilized to accomplish all this.

NASMHPD is the organization representing the state executives responsible for the $41 billion public mental health service delivery systems serving 7.5 million people annually in 50 states, 4 territories, and the District of Columbia.

We would start off by suggesting that the Finance Committee staff should review the December report to Congress from the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), an entity that includes representation from 10 Federal agencies. Although ISMICC's 45 recommendations in five different focus areas were intended to address how the Federal government might address issues of serious mental illness, many—if not most—individuals with substance use disorders have co-occurring mental health issues that drive them to engage in the abuse of substances. And most of the ISMICC recommendations for addressing gaps in mental health prevention and treatment at the Federal level are equally applicable to addressing the abuse of opioids and other substances.

But, more specifically, we make the following recommendations:

(1) **Maintain Mandated Medicaid Coverage of Substance Use Disorder Mental Illness Treatment and Prevention**
The Medicaid program must continue to mandate coverage of substance use disorder treatment and prevention, as well as coverage of the mental health conditions which so often co-occur. The elimination of Medicaid expansion would leave without coverage the 1.3 million childless, non-pregnant adults with serious mental illness who were able, for the first time, to gain coverage under Medicaid expansion. It would also leave uncovered the 2.8 million childless, non-pregnant adults with substance use disorders who gained coverage under expansion for the first time. Medicaid is the single largest payer for behavioral health services in the

U.S, accounting for about 27 percent of behavioral health spending. It covers a broad range of behavioral health services at low or no cost, including psychiatric hospital care, case management, day treatment, evaluation and testing, psychosocial rehabilitation, medication management, as well as individual, group and family therapy. In 43 states, Medicaid covers essential peer support services to help individuals with substance use disorders and/or mental illness sustain recovery. In states that have expanded Medicaid and which have been particularly hard hit by the opioid crisis, until the 21st Century Cures Act state grants were distributed, Medicaid paid between 35 to 50 percent of the costs of medication-assisted treatment for substance use disorders.

Because people with behavioral health disorders experience a higher rate of chronic physical conditions than the general population, it is also important to remember that untreated substance use disorders or mental illness intensifies and serves to increase the number of co-morbid medical conditions in those populations, thereby multiplying total Medicaid program and private insurance costs.

We would also urge that the Centers for Medicare and Medicaid Services (CMS) State Medicaid Director Letter #17-003 on § 1115 substance use disorder continuum of care waivers permitting Medicaid coverage of inpatient (IMD) care be codified to be made permanent. While inpatient care is not and should not be the only remedy for individuals in substance use disorder crisis, it is an important tool in the toolkit, particularly in those communities lacking community-based crisis stabilization services. At the same time, we would urge that Medicare program coverage be revised to allow for coverage for all crisis stabilization services—coverage currently provided only for some stabilization services—and that their availability be incentivized as part of any value-based Medicaid or Medicaid managed care program model.

But substance use disorders must also be addressed outside the practice silos that are often endemic to our current health care system. Medicaid- and Medicare-participating primary care and pediatric health care providers and providers under private insurance, must be trained in how to prevent, identify, and treat substance use disorders, as part of the medical school training in any teaching hospital receiving Federal assistance of any kind, so that they know to screen for substance use disorders as part of any periodic/annual prevention screenings. This is important because PCPs and pediatricians are often the only providers that enrollees, particularly children, see with any regularity. And, of course, substance use disorders are often co-occurring and causative of general medical maladies experienced by a patient with a disorder. Reimbursement should be included in the reimbursement for any other screening under the Medicaid and Medicare programs, preferably as part of any value-based treatment package.

(2) **Align the Restrictions on the Sharing of Substance Use Disorder Diagnosis, Treatment, and Referral Information, Contained in 42 Code of Federal Regulations Part 2, with the Information Disclosure Regulations Under the Health Insurance Portability and Accountability Act (HIPAA), While Guarding Against Disclosure Outside the Care Team**

NASMHPD notes the Finance Committee's interest in sharing information between the Medicaid and Medicare programs and PDMPs, but that information-sharing is limited under current lawbecause of the restrictions on the sharing of diagnosis, treatment, and referral information without specific patient consent outlined under 42 CFR Part 2 and its underlying statute, 42 U.S.C. § 290dd–2. That statute, enacted in the 1970s, well before HIPAA, and its regulations prohibit the sharing of treatment information—including pharmaceutical treatment—among treating providers. While the Substance Abuse and Mental Health Services Administration recently relaxed those restrictions to permit sharing for purposes of operations and payment, the conduit of that sharing, Health Information Exchanges, are still reluctant to share substance use diagnosis, treatment, and referral information because of ambiguity in what the relaxed regulations mean, the need to still obtain consent from the patient (who is likely to

be reluctant or unable to share information about his or her abuse of substances), and the expense and technological difficulty in redacting SUD information from patient information. The sharing of PDMP information would still need to be guarded against disclosure to criminal law authorities, prohibited under both 42 CFR Part 2 and HIPAA, and against disclosure in civil and administrative proceedings—concerns being addressed in legislation currently before Congress which we would hope the Finance Committee would support.

(3) **Make Medication-Assisted Treatment (MAT) More Widely Available –** The $1.1 billion in grants authorized under 21st Century Cures has helped to make medication-assisted treatment more widely available, but additional action must be taken. Medicaid- and Medicare-enrolled health care providers must be trained in the administration of MAT. The current arbitrary restriction imposed by the Drug Enforcement Administration requiring that providers be engaged in MAT administration for one year before they may increase the number of patients they treat should be replaced with a skills- and experience-based trigger. Currently, only about 5 percent of the nation's physicians have obtained waivers to administer buprenorphine.

State-licensed Medicaid and Medicare-enrolled addiction treatment providers should be trained and able to provide access to MAT in order to be enrolled. Medicaid-enrolled Community Health Centers and Federally Qualified Health Centers should be incentivized through payment to administer MAT as part of their services. MAT administration should be included in any evidence-based model of care for substance use treatment. And telehealth laws and regulations under both the Medicaid and Medicare programs should be revised to permit assessment of the need for, and prescribing of, MAT remotely—an essential change for rural and frontier-remote and inner-city locations with few or no readily available or accessible behavioral health providers. Finally MAT access should be reimbursed by Medicaid and Medicare in jails and prisons for individuals transitioning into the community, in the last month of incarceration, to reduce the Medicaid costs of ex-offenders once they are in the community and prevent their recidivism.

The Medicare formulary, Medicare Advantage formularies, and Medicaid preferred drug lists, and private insurance formularies within the ACA exchanges should cover reimbursement for MAT. Access alone is not enough; the drugs themselves must be readily affordable. Until formulary coverage can be achieved, the Federal government should continue to make grants available to the states to allow for state purchase of those drugs.

(4) **Incentivize, Facilitate, or Mandate Prescribing and Dispensing Provider Buy-In -** NASMHPD believes limiting outlier and noncompliant patients to a pharmacy lock-in has been shown to be an effective tool for monitoring and restricting Medicaid and Medicare enrollees' abuse of prescribed substances and we would urge the adoption of this tool throughout both programs. The 2016 Center for Disease Control and Prevention guidelines limiting the timeframe for prescribing opioids to treat short-term, acute pain and limiting the use of extended-release medications should be mandated for prescribers throughout both the Medicare and Medicaid programs. Prescribers and pharmacists should be monitored, and outliers who prescribe or dispense opioids too frequently or in too-large doses—with the possible exception of oncologists—should be identified in a database posted on the CMS website. CMS should be asked to study under a demonstration pilot whether Medicaid and Medicare reimbursement policies should be revised, and whether state Medicaid programs should be encouraged to cover, non-pharmaceutical pain treatments such as acupuncture. Such studies should include the use of behavioral health and general medical outcome measures.

CMS should also be directed to mandate the use of electronic prescribing in prescribing opioids so that prescribing data can easily be transmitted to state Prescription Drug Monitoring Program databases.

Interstate access to PDMP databases should be mandated for the Medicaid and Medicare programs, but access should remain restricted to providers and programs and disclosure not be permitted for use by criminal justice authorities, in criminal courts, or in administrative or civil court proceedings.

(5) **Workforce is a Crucial Element in Any Wide-Ranging Approach to the Opioid Crisis -** The Health Resources and Services Administration, as of June 30, 2017, found that only 43.4 percent of the need for mental health professionals is met nationwide (down 8/10 of a percent in the six months since December 31, 2016), with 3,474 additional professionals needed in the 4,627 Mental Health Care Health Professional Shortage Areas designated by HRSA. Only half of all states met 50 percent or more of their mental health care need, while some states fail to meet even a quarter of their need.

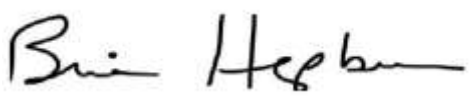
There are only 8.9 practicing full-time psychiatrists for every 100,000 individuals in the U.S, and of the approximately 28,250 psychiatrists active in 2015, 59 percent were 55 years of age or older. In hospital emergency departments, the wait for psychiatric services averages up to 23 hours for some dispositions, according to a March 28 report by the National Council on Behavioral Health's Medical Directors Institute, *The Psychiatric Shortage: Causes and Solutions*. That same report finds that the pool of psychiatrists working with public sector and insured populations declined by 10 percent between 2003 and 2013. Fifty-five percent of states have a "serious shortage" of child and adolescent psychiatry

While not every treatment for substance use necessarily requires the presence of a psychiatrist—although states and the Medicare program generally require supervision by a treating physician—the shortage of psychiatrists has led to reduced access to substance use disorder and mental health services. The number of Medicare Graduate Medical Education Residencies in psychiatry at teaching hospitals should be increased, and quickly, and both the Medicare and Medicaid programs should ensure that substance use and mental health providers are reimbursed at parity with their general medical and specialist professional counterparts. Physician assistants and advanced nurse practitioners should be adequately trained in administering to the substance use disorder patient, and authorized to administer MAT in the absence of physician supervision under both the Medicare and state Medicaid programs.

Finally, the Medicare program reimbursement policy should be amended to permit what Medicaid programs in 43 states already do under State Medicaid Director Letter #07-011—cover peer support so that recovering individuals with substance use disorders can continue to receive necessary support and guidance while in treatment and, later, in the community from a person who has lived the same experience. Peer support has been found to be highly effective in helping individuals with substance use disorders and mental illness achieve and maintain their recovery.

Please feel free to reach out to me by email or by phone at 703-682-5181 or to NASMHPD's Director of Policy and Communications, Stuart Yael Gordon, by email or by phone at 703-682-7552 with any questions regarding this letter.

Sincerely,



Brian Hepburn, M.D.
Executive Director
National Association of State Mental Health Program Directors (NASMHPD)