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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

June 13, 2015

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "H.R. 2646, *the Helping Families in Mental Health Crisis Act*" and "H.R. 2690, *the Including Families in Mental Health Recovery Act of 2015"*

On Tuesday, June 16, 2015 at 10 a.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Health will hold a legislative hearing on H.R. 2646, the Helping Families in Mental Health Crisis Act; and H.R. 2690, the Including Families in Mental Health Recovery Act. H.R. 2646 is sponsored by Rep. Murphy (R-PA) and was introduced on June 4, 2015. H.R. 2690 is sponsored by Rep. Matsui (D-CA) and was introduced on June 9, 2015. More information on this legislation is provided below.

This memo will provide a brief background on serious mental illness, and an overview of selected topics related to the legislation including, mental health parity, recent updates and other advances made in the mental health field by the Affordable Care Act, an overview of the Medicaid IMD Exclusion, and health information privacy issues raised with respects to serious mental illness.

I. BACKGROUND - SERIOUS MENTAL ILLNESS

Serious mental illnesses include medical conditions such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, and borderline personality disorder.[1] These conditions are described as severe when they have a significant and persistent manifestation. Approximately 10 million adults in the United States live with a serious mental illness.[2]

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[1] National Alliance on Mental Illness, *What is Mental Illness: Mental Illness Facts* (online at www.nami.org/template.cfm?section=about_mental_illness).

[2] Substance Abuse and Mental Health Services Administration, *Behavioral Health Barometer* (2014).

Individuals with serious mental illness can be treated effectively. According to the National Alliance on Mental Illness, "between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports."[3]

There are significant barriers to receiving treatment and recovering, however, including a shortage of treatment facilities, lack of access to a wide range of treatment and support services, and the stigma associated with serious mental illness and treatment. As a result, many individuals with serious mental illnesses are not receiving effective treatment or experience delays in treatment. On average, there is a 110-week delay between an initial episode of psychosis and the commencement of medical treatment.[4] For those adults living with a serious mental illness, 46 percent did not receive treatment in the past year.[5]

II. MENTAL HEALTH PARITY

A. The Mental Health Parity and Addiction Equity Act of 2008 as amended by the Affordable Care Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) builds on the original Mental Health Parity Act of 1996 and provides important protections regarding equivalency of coverage for medical, surgical, and mental health and substance use disorder services that expands access to mental health treatment. Essentially, MHPAEA requires that financial requirements (such as deductibles and co-payments) and treatment limitations (such as number of visits) for mental health and substance use disorder services are "no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits."[6]

MHPAEA was further strengthened by the Affordable Care Act (ACA) in 2010. The ACA extended coverage from group health plans and group health insurance coverage to also apply to individual health insurance. MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly in connection with the ACA's essential health

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[3] National Alliance on Mental Illness, *What is Mental Illness: Mental Illness Facts* (online at www.nami.org/template.cfm?section=about_mental_illness)(accessed Mar. 24, 2014).

[4] M. Marshall et al., *Association between duration of untreated psychosis and outcome in cohorts of first-episode patients*, Archives of General Psychiatry (Sept. 2005).

[5] *Supra note 2.*

[6] Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (accessed Mar. 24, 2014).

benefit (EHB) requirements. Key provisions of MHPAEA also apply to Medicaid managed care, Medicaid benchmark plans, and the Children's Health Insurance Program (CHIP).

The final regulation implementing MHPAEA went into effect on January 13, 2014, and generally applies to plan or policy years beginning on or after July 1, 2014.[7] The final regulation applies to large employers' insurance plans (non-Federal governmental plans with more than 100 employees), and to group health plans of private employers with more than 50 employees.
It also applies to health insurance coverage in the individual health insurance market. Provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) further made clear that CHIP plans, Medicaid benchmark benefit plans, and managed care plans that contract with state Medicaid programs to provide services are required to comply with key parity provisions of MHPAEA.[8]

III. THE AFFORDABLE CARE ACT

A. The ACA Expands Critically Needed Access to Mental Health and Substance Abuse Treatment through Medicare, Medicaid and the Health Insurance Marketplaces

The ACA provides affordable and quality insurance coverage to tens of millions of Americans. As part of these offered benefits, all new individual and small group insurance plans are mandated to cover mental health and substance use disorder services as one of ten Essential Health Benefits. The ACA law requires insurance plan groups to cover these services at parity with medical and surgical benefits, significantly expanding access to these lifesaving services.[9] As a result, individuals are able, through ACA-established, federal and state Health Insurance Marketplaces to compare high-quality health insurance plans and purchase affordable coverage – often with the help of tax credits and cost-sharing reductions.

The ACA also gives states the ability to expand Medicaid coverage to individuals with incomes at or below 138 percent of the federal poverty level. The federal government will fully

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[7] U.S. Department of the Treasury, U.S. Department of Labor, and U.S. Department of Health and Human Services, *Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program;* 78 Fed. Reg. 219 (Nov. 13, 2013) (final rule).

[8] See http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf for the State Health Official letter regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans.

[9] Healthcare.gov, *Essential Health Benefits* (online at www.healthcare.gov/glossary/essential-health-benefits/) (accessed Mar. 24, 2014); Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html)(accessed Mar. 24, 2014).

cover Medicaid expansion costs, through 2016. The federal government will decrease its matching cost share at a slowly decelerating pace to cover 90 percent of states' Medicaid expansion costs by 2020.[10] States expanding their Medicaid programs must offer Essential Health Benefits -- including coverage for mental health and substance use conditions -- to newly-eligible beneficiaries and cover these services at parity with medical and surgical benefits.[11]

Twenty-nine states plus the District of Columbia have expanded their Medicaid programs, and Medicaid and CHIP enrollment has increased by 12.2 million since October, 2013. Currently, nearly 71.1 million individuals are enrolled in Medicaid and CHIP nationwide.[12] Had all 50 states participated in Medicaid expansion, nearly 925,000 uninsured people diagnosed with a serious mental health condition in 2014, could have accessed affordable and needed treatments.[13]

Health insurance through the ACA stands to greatly benefit people with mental health and substance use conditions by making early treatment and prevention services more accessible, which will avert crisis situations from arising in the first place.[14]

Notwithstanding expanded access to and availability of these critical services and treatments, 22 states have declined to move forward with Medicaid expansion. As a result, an estimated 3.7 million, uninsured adults with mental health and substance use conditions will be unable to obtain Medicaid health insurance coverage. This includes nearly 800,000 individuals with a serious mental illness; over 1.5 million individuals suffering from serious psychological

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[10] Kaiser Family Foundation, *Quick Take: Who Benefits from the ACA Medicaid Expansion?* (June 14, 2012)(online at kff.org/health-reform/fact-sheet/who-benefits-from-the-aca-medicaid-expansion/).

[11] Healthcare.gov, *Essential Health Benefits* (online at www.healthcare.gov/glossary/essential-health-benefits/); Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html).

[12] Centers for Medicare and Medicaid Services, *Medicaid & CHIP: March 2015 Monthly Applications and Eligibility Determinations Report* (June 4, 2015) (online at http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/2015-march-enrollment-report.pdf).

[13] American Mental Health Counselors Association, *Access Denied: Non-Medicaid Expansion States Blocked Uninsured People with Serious Mental Illness from Receiving Affordable, Needed Treatments.* (March 2015) (online at http://www.amhca.org/?page=reports).

[14] *Id.*

distress, such as panic, anxiety, and mood disorders; and nearly 1.4 million individuals dealing with a substance use disorder.[15]

A report by the American Mental Health Counselors Association found that over 2.7 million Americans with a serious mental health condition in 34 states that have not established their own ACA-related exchanges or expanded Medicaid coverage in their states, are at risk of becoming or remaining uninsured should the Supreme Court, later this month, roll back insurance coverage subsidies for individuals living in those select states.[16]

1. *Medicaid Health Homes*

Medicaid Health Homes provide services such as comprehensive care management, health promotion, transitional and follow-up care, patient and family support, and referrals to community and social support services.

Section 2703 of the ACA gives states the option to create Health Homes to coordinate care for individuals with chronic conditions in the Medicaid program. Individuals who have one serious and persistent mental health condition, two chronic conditions (including mental health, substance abuse, asthma, diabetes, heart disease, and being overweight), or one chronic condition with risk for a second are considered eligible.

CMS will provide an enhanced Medicaid matching rate of 90 percent for Health Home services.[17] CMS has approved Health Home state plan amendments in 14 states. Another 11 states and the District of Columbia have submitted state plan amendments to CMS for approval.[18]

2. *Health Care Innovation Awards (HCIA) at the Center for Medicare and Medicaid Innovation (CMMI)*

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[15] American Mental Health Counselors Association, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness* (Feb. 2014) (online at http://www.amhca.org/?page=reports).

[16] American Mental Health Counselors Association, *Pulling the Rug Out from Under: Over Two Million People with Serious Mental Illnesses Would Become Uninsured if the Supreme Court Kills Health Insurance Subsidies* (March 2015) (online at http://www.amhca.org/?page=reports).

[17] Centers for Medicare and Medicaid Services, *Health Homes* (online at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html) (accessed Mar. 24, 2014).

[18] Centers for Medicare and Medicaid Services, *State Health Home CMS Proposal Status* (Mar. 2014) (online at www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v31.pdf).

The ACA authorized the Center for Medicare & Medicaid Innovation (CMMI) to test innovative health care payment and service delivery models with the potential to lower spending on Medicare, Medicaid, and CHIP services while maintaining or improving beneficiaries' health and the quality of care they receive. Ten awardees in the first round of the HCIA initiative have focused specifically on mental health and substance abuse services and are implementing a wide array of interventions.

The awardees' projects include certain cross-cutting themes (e.g., innovative approaches to care coordination and new roles in the workforce) but focus on different subgroups within this broad priority population, such as individuals with schizophrenia or with serious mental illness coupled with chronic physical conditions. The awardees also are implementing their interventions in a range of clinical settings, including community sites, medical practices, and mental health clinics.[19] The projects have already generated significant insights into creative, successful interventions for those with serious mental illness. In fact, one such awardee who is providing respite care services for the seriously mentally ill, Parachute NYC, will testify at our hearing.[20]

IV. MEDICAID IMD EXCLUSION

Current law prohibits the federal government from providing Medicaid matching funds for inpatient treatment of adults ages 21 to 64 in psychiatric institutions that have more than 16 beds, known as institutions for mental disease (IMDs). Importantly the IMD exclusion applies only to psychiatric hospitals with more than 16 beds for adults ages 21-64; federal law exempts other populations from the IMD exclusion.

The first exemption, which has existed since Medicaid's enactment in 1965, applies to adults ages 65 and older who receive services in institutions for mental diseases. The second exemption, added in 1972, applies to children under age 21 (or in certain circumstances, under age 22). In the case of children, inpatient psychiatric hospital care is a coverage option but is mandatory when a child's condition is diagnosed through their State provided medical benefits, known as an Early and Periodic Screening, Diagnostic and Treatment, or EPSDT.

The Medicaid IMD exclusion grew out of concerns regarding the practice of the time to institutionalize the severely mentally ill in large psychiatric institutions, where care was often substandard. There was also a growing recognition of the importance of community-based care as an alternative. However, as the care landscape has changed and particularly in light of an increasingly apparent shortage of beds for this population, many have called for flexibility in the IMD exclusion for this population. Two such efforts are a reflection of new IMD flexibility; the

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[19] Mathematica Policy Research, *Evaluating the HCIA-Behavioral Health/Substance Abuse Awards: First Annual Report* (December 11, 2014) (online at http://innovation.cms.gov/Files/reports/HCIA-BHSA-FirstEvalRpt.pdf).

[20] On July 1, 2012, the Fund for Public Health in New York, Inc., on behalf of the New York City Department of Health and Mental Hygiene (DOHMH), was awarded $17.6 M over 3 years to launch Parachute NYC. More information about Parachute NYC and the innovation grant can be found at http://www.nyc.gov/html/doh/html/mental/parachute.shtml)

Medicaid Emergency Psychiatric Demonstration Program, and CMS' newly announced proposed regulation for Medicaid Managed Care.

1. Medicaid Managed Care Proposed Regulatory Changes to the Medicaid IMD Exclusion

The Medicaid IMD exclusion is an explicit part of the federal Medicaid statute.[21] However, CMS has more flexibility when regulating Medicaid managed care arrangements.
Approximately 70 percent of Medicaid enrollees are served through managed care delivery systems.[22] On May 26, 2015, the Centers for Medicare & Medicaid Services (CMS) proposed the first Medicaid managed care regulation in more than a decade to modernize and update the programs' rules and strengthen the delivery of quality care for beneficiaries. The proposed regulation partially mitigates the IMD exclusion. Specifically, the proposed rules would distinguish between short-term treatment and residential care, permitting states to include short-term stays in their capitation payments. Stays would be limited to fewer than 15 days in any month, with flexibility to create longer stays by aligning stays over two consecutive months (14 days in one month and 14 in the next).

2. Medicaid Emergency Psychiatric Demonstration Program

Section 2707 of the ACA authorized a demonstration program providing Medicaid reimbursement to private IMDs for emergency inpatient psychiatric care.[23] Twenty-seven private IMDs in 11 states and the District of Columbia are participating in the demonstration, which began in 2012 and is scheduled to end in December 2015, with a final evaluation report available in September 2016. Bipartisan Senate legislation (S. 599) has been introduced to extend the demonstration project.

In its December 2013 report to Congress, CMS states: "[W]e do not have enough data to recommend expanding the demonstration at this time; given the limited data, however, we recommend that the demonstration continue through the end of the current authorization, December 31, 2015, to allow a fuller evaluation of its effects."[24] Proponents of eliminating the IMD exclusion expect that the demonstration will increase the number of inpatient beds, lead states to reallocate savings to improving community-based services, reduce psychiatric boarding in emergency rooms, decrease hospital readmissions, and decrease overall Medicaid costs.[25]

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[21] The IMD exclusion is found in section 1905(a)(B) of the Social Security Act.

[22] *See* http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html.

[23] Centers for Medicare and Medicaid Services, *Report to Congress on the Evaluation of the Medicaid Emergency Psychiatric Demonstration* (Dec. 1, 2013).

[24] *Id.*

[25] *Id.*

V. SUMMARY-H.R. 2646, HELPING FAMILIES INMENTAL HEALTH CRISIS ACT

A. TITLE I – Assistant Secretary for Mental Health and Substance Use Disorders

This title would create a new Assistant Secretary for Mental Health and Substance Use Disorders position within HHS. The Assistant Secretary would be a Senate-confirmed position and report directly to the Secretary of HHS. Among other requirements, the legislation would require the Assistant Secretary to be a physician or clinical psychologist.

The legislation would eliminate the Substance Abuse and Mental Health Services Administration (SAMHSA). All SAMHSA duties and authorities, including grant-making, would be transferred to the Assistant Secretary within 6 months of enactment. The legislation would establish additional duties and authorities for the Assistant Secretary. The legislation would require the Assistant Secretary to prioritize workforce development in addition to the integration of services, early diagnosis, and interventions in carrying out those additional authorities.

Among other duties, the Assistant Secretary would carry out <u>any</u> HHS function to improve treatment services and prevention services; ensure access to effective, evidence-based treatment for individuals with mental illness or substance use disorder; ensure grant programs adhere to scientific standards; and develop and implement initiatives to encourage individuals to pursue mental health careers focused on the treatment of individuals with severe mental illness. The Assistant Secretary would oversee and coordinate <u>all</u> HHS programs and activities related to the prevention, treatment, or rehabilitation of/for mental health and substance use disorders, mental health parity, and reduction of homelessness among individuals with mental illness.

The legislation would establish requirements on the Assistant Secretary's grant-making authority. Those requirements would include limiting grant funding to only those programs and activities that use evidence-based or emerging evidence-based best practices.

The legislation would require the Assistant Secretary to issue several reports. They include: investigations regarding mental health parity; best practices for peer-support specialist programs, training, and certification; and the state of the states in mental health and substance abuse treatment. The Assistant Secretary would be required to release a nationwide strategy for increasing the psychiatric workforce and recruiting medical professionals for the treatment of individuals with serious mental illness and substance use disorders. The legislation would require the Assistant Secretary to contract with the Institute of Medicine to issue a report within 12 months of enactment evaluating the combined paperwork burden on community mental health centers and federally qualified community mental health clinics.

B. TITLE II – Grant Reform and Restructuring

The legislation would create a National Mental Health Policy Laboratory (NMHPL) within the Office of the Assistant Secretary. The legislation would establish the staffing composition of the NMHPL, including a requirement that the greater of 20 percent of or two staff members of the NMHPL be appointed by Congress. Among other responsibilities, the NMHPL would be tasked

with identifying and implementing policy changes likely to have the most significant impact on mental health services; evaluating and disseminating to grantees evidence-based practices and service delivery models; and issuing a biennial report on the quality of care furnished through grant programs administered by the Assistant Secretary. The legislation would require the Assistant Secretary to comply with standards established by the NMHPL for grant programs administered by the Assistant Secretary.

The legislation would create several new mental health grant programs that would be funded through a tap on SAMHSA's general authorization as well as mental health and substance abuse programs of regional and national significance (PRNS). Those programs include Innovation Grants, Demonstration Grants, and Crisis Intervention Grants. The cumulative impact of those taps would be a 20 percent reduction in funding for PRNS and SAMHSA's general account. This means that the legislation would take funding from substance abuse programs (and existing mental health programs) to pay for the new mental health grant programs.

The Innovation Grant Program would award funding for expanding models that either enhance the screening, diagnosis, and treatment of mental illness or integrate or coordinate physical, mental health, and substance use services that have been scientifically demonstrated to show promise but would benefit from further applied research. This program would be funded by a 5 percent tap of PRNS and SAMHSA's general account. The Demonstration Grant Program would award funding for expanding evidence-based programs to enhance effective screening, early diagnosis, intervention, and treatment with respect to mental illness. This program would be funded by a 10 percent tap of PRNS and SAMHSA's general account. The legislation would authorize a Crisis Intervention Grant Program to provide crisis intervention grants to train police officers and first responders how to intervene with individuals with mental illness. This grant program would be funded by a tap of 5 percent of PRNS and SAMHSA's general account.

This legislation would amend the Protecting Access to Medicare Act to extend the authorization for the assisted outpatient treatment (AOT) grant program from FY 2018 to FY 2020 and increase the authorization of appropriations from $15 million to $20 million per year. The legislation would also require that 20 percent of funding for the AOT grant program be allocated to existing programs and 80 percent to new programs.

The legislation would establish new requirements for states to be eligible for the Community Mental Health Block Grant (MHBG). The title would require states, in order to receive MHBG funding, to have in effect a law that provides for involuntary outpatient treatment that requires individuals to obtain outpatient mental health treatment (AOT laws) and laws that require a civil court to order involuntary inpatient or outpatient treatment for an individual if the court finds that an individual, as a result of a mental illness, is a danger to self or others, "is persistently or acutely disabled, or is gravely disabled and in need of treatment" (Treatment Standard laws). The legislation would also increase by 2 percent the MHBG allotment amount for states that have in effect AOT laws or Treatment Standard laws. The legislation also would require states to have programs in place, including AOT laws, for the active outreach and engagement of individuals with serious mental illness.

The legislation would add new requirements of what must be included in state plans detailing the use of MHBG funds for comprehensive community-based mental health services for children with serious emotional disturbance and adults with serious mental illness. Among those requirements would be a plan for the integration of primary and behavioral health care, a detailed list of services available in each county, and de-identified information about certain patients receiving treatment under the MHBG. The legislation would require a 5 percent set-aside of the MHBG for the Secretary, acting through the Director of the National Institute of Mental Health (NIMH), to translate evidence-based medicine into clinical care models.

The legislation would also create the Early Childhood and Intervention Grant that would award grants for early childhood programs aimed at preventing chronic and serious mental illness and to entities for studying the longitudinal outcomes of those early childhood programs. This program would be funded by a 5 percent set-aside of the MHBG for children with serious emotional disturbance from FY 2016 to FY 2021.

The legislation would authorize several grant programs for workforce development. The legislation would authorize a Telepsychiatry and Primary Care Physician Training Grant program to award 10 states grants to carry out all of the following: a training program for primary care physicians, payments for mental health services provided by certain primary care physicians, and telehealth services for mental health disorders. The legislation would authorize the Minority Fellowship Program (MFP) at a funding level of $6 million which is less than the $10.669 million the MFP received in FY 2015. The MFP provides funding for individuals from underserved minority populations to obtain graduate degrees in mental health professions. SAMHSA currently administers the MFP under SAMHSA's PRNS authorities.

The legislation would amend certain definitions under the National Health Service Corps (NHSC) with the intent to allow child and adolescent psychiatry residents to participate in the NHSC Loan Repayment Program.

The legislation would authorize the National Suicide Prevention Lifeline Program (Lifeline) at a funding level of $8 million. The Lifeline is a 24-hour, suicide prevention hotline. SAMHSA currently administers the Lifeline under SAMHSA's PRNS authorities.

This title would reauthorize programs that have broad bipartisan support, including the Garrett Lee Smith Suicide Prevention Program and the National Child Traumatic Stress Initiative (NCTSI). However, the legislation would make concerning changes to both programs. The legislation would reauthorize theNCSTI for FY 2014 through FY 2018 at $45.713 million which is less than the $45.887 million the NCSTI received in FY 2015.

The legislation would reauthorize the Garrett Lee Smith Act grant programs for FY 2016 through FY 2020. This includes the Suicide Prevention Technical Assistance Center Grant Program at $4.957 million (which is less than the $5.988 million the program received in FY 2015), the Youth Suicide Early Intervention and Prevention Strategies Grant Program at $29.738 million (which is less than the $35.427 million the program received in FY 2015) andthe Mental Health and Substance Use Disorders Services on Campus Grant Program at $4.975 million (which is less than the $6.488 million it received in FY 2015).

Within the language reauthorizing the Garrett Lee Smith Act grant programs, the legislation contains an abortion prohibition. Under current law, the three Garrett Lee Smith Act grant programs are prohibited from using grant funding to pay for or refer for abortion services. This legislation explicitly maintains that restriction but also extends that restriction to the SAMHSA's Projects for Assistance in Transition from Homelessness, or PATH, Program. The PATH Program is a formula grant program to the 50 states, D.C., and the U.S. Territories that provides services to people with serious mental illness who are experiencing homelessness or are at imminent risk of becoming homeless. Currently, no such restriction exists in the statutory language authorizing the PATH Program, but the Hyde restriction that is included in the annual appropriations legislation would apply. It is also important to note that this language goes beyond the Hyde language because it not only applies to the payment for abortion services but also to referring for abortion services.

The Secretary of Education, along with the Assistant Secretary, would be required to organize a national awareness campaign to help students reduce the stigma associated with and understand the importance of seeking treatment for serious mental illness. The campaign would target high school and college students.

This legislation would extend federal malpractice liability coverage to health care professional volunteers who are providing specified services at community health centers and Federally-Qualified Community Behavioral Health Clinics.

C. TITLE III – Interagency Serious Mental Illness Coordinating Committee

The legislation would establish an Interagency Severe Mental Illness Coordinating Committee of Federal and non-Federal members to support the Assistant Secretary in carrying out his/her duties. The members would include 4 members who are politically appointed; one appointment each by the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the Majority Leader of the Senate, and the Minority Leader of the Senate. This could politicize the Committee. Among other duties, the Committee would have to develop, annually update, and submit to Congress a strategic plan for increasing utilization of mental health services and compliance with treatment.

D. TITLE III – HIPAA and FERPA Caregivers[26]

This title would make changes to current Health Insurance Portability and Accountability Act (HIPAA) provisions as they relate to provider disclosure of protected health information to family members and individuals who "assume primary responsibility" of a patient with a serious mental illness. It would provide a new exception to the HIPAA privacy rule, intended to address situations in which providers have refused to disclose information to family members regarding a patients' treatment.

[26] HIPAA comments are included in this memo. FERPA is outside of E&C's jurisdiction.

However, HIPAA already gives providers broad discretion to share information with family members and caregivers if it would aid an individual's treatment. Problems with applications of the rule appear to be largely attributable to provider misperceptions regarding their duties and obligations under HIPAA.

The HHS Office of Civil Rights has recently issued guidance to clarify providers' obligations.[27] Unless a patient objects, HIPAA already provides a clear path to communicate with family. In recognition of the important role that family members play in a patients' care, the HIPAA rule allows providers to communicate with a patients' family members or others involved in his or her healthcare, so long as the patient does not object.[28] Even if the patient does object, health care professionals can make disclosures of protected health information, if the provider has a good faith belief that the disclosure is "necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public."[29] If a patient is incapacitated, for instance due to temporary psychosis or under the influence of drugs or alcohol, and cannot meaningfully agree or object to the sharing of information with caregivers, the provider can share information with the caregivers if it would be in the patients' best interests.[30]

The legislation also would include a new exception to the privacy rules surrounding the treatment of substance abuse disorders. Under current law, there are additional protections for records pertaining to the identity, diagnosis, or treatment of patients with substance abuse disorders.[31] These laws and regulations were enacted three decades ago in recognition of the stigma associated with substance abuse and fear of prosecution that deterred people from entering treatment. For instance, providers must maintain written consent for disclosures of protected health information, even for the purposes of treatment or payment (which is not required under HIPAA).[32]

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[27] U.S. Department of Health and Human Services, *HIPAA Privacy Rule and Sharing Information Related to Mental Health* (online at www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html)(February 20, 2014).

[28] 45 C.F.R. 164.510(b).

[29] 42 C.F.R. 164.512(j).

[30] U.S. Department of Health and Human Services, *HIPAA Privacy Rule and Sharing Information Related to Mental Health* (online at www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html) (February 20, 2014).

[31] 42 U.S.C. 290dd-2.

[32] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Overview of Alcohol/Drug Confidentiality Regulations- 42 C.F.R. Part 2* (online at www.integration.samhsa.gov/clinical-practice/mat/Webinars_2012_Overview_of_Alcohol_and_Drug_Confidentiality_Regulations-_42_CFR_Part_2.pdf).

The regulation would exempt accountable care organizations, health information exchanges, health homes, or other integrated care arrangements from existing privacy and consent requirements, for purposes of "attaining interoperability, improving care coordination, reducing health care costs, and securing or providing patient safety." Some stakeholders have expressed concern that this would open up substance abuse treatment records to hundreds and even thousands of providers, many of whom do not have a clinical relationship with the patient.

However, some providers have argued that these privacy regulations present a hurdle to the treatment of patients with substance abuse disorders, particularly in light of the movement in our healthcare system towards coordination of care and integration of mental and physical healthcare.[33] SAMHSA has solicited input from stakeholders on updating the regulations and is expected to issue proposed changes in the near future.[34]

E. TITLE V – Medicare and Medicaid Reforms

This section would restrict state Medicaid programs from prohibiting payment for a mental health or primary care services provided at a community mental health center or a federally qualified health center when the mental health service was received on the same day as the primary care service or vice versa.

It would eliminate the IMD exclusion in Medicaid by authorizing federal matching payment for services provided in an inpatient psychiatric residential treatment facility or psychiatric residential treatment facility for individuals ages 21 to 64 if the Chief Actuary of CMS certifies that this change would not increase federal Medicaid spending. It also would eliminate the 190-day lifetime limit on inpatient psychiatric services under Medicare if the Chief Actuary of CMS certifies that this change would not increase federal Medicare spending. It is unlikely that either provision would be implemented under such requirements since both changes would result in increased spending.

This title would make permanent the inclusion of antipsychotics and antidepressant drugs as protected drug classes under Medicare Part D. That means that Medicare Part D plans must provide all drugs within those classes.

The bill would prohibit state Medicaid programs from excluding coverage for drugs used for the treatment of a mental health disorder, including major depression, bipolar (manic-depressive) disorder, panic disorder, obsessive compulsive disorder, schizophrenia, and schizoaffective disorder. The provision explicitly applies this requirement to Medicaid managed care plans. This provision seems to protect broad classes of drugs that are used to treat a wide range of mental health conditions. For example Adderall used for attention deficit hyperactivity disorder would be considered a drug to used treat a mental health condition, but may not be what the legislation intends to protect.

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[33] See, e.g., House Committee on Energy and Commerce, *Hearing on Combatting the Opioid Abuse Epidemic: Professional and Academic Perspectives*, 114th Cong. (Apr. 23, 2015).

[34] Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Notice of Public Listening Session*, Federal Register (May 12, 2014).

In addition, the bill would require the Secretary of HHS to develop and issue, through regulations, guidelines and standards for new discharge planning requirements for psychiatric hospitals.

It would also amend the 2-year, 8 state demonstration program to improve services provided by certified community behavioral health clinics included in the Protecting Access to Medicare Act by extending the demonstration to 4 years and by increasing the maximum number of states to ten.

F. TITLE VI – Research by the National Institute of Mental Health

This title would authorize $40 million a year from FY 2016 through 2020 for the National Institute of Mental Health (NIMH) -- beyond amounts currently available for the Institute -- for research on: (1) the determinants of self- and other directed-violence in mental illness; and (2) the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. This specific authorization of appropriations for NIMH research does not follow the standard authorization convention of just having a single, agency- wide authorization for the National Institutes of Health (NIH).

G. TITLE VII – Behavioral Health Information Technology

This title allows behavioral and mental health providers to receive incentive payments for the meaningful use of health information technology.

H. TITLE VIII – SAMHSA Reauthorization and Reforms

This title would require at least half of the members of any peer review group established to review proposals or grants to be physicians, clinical psychologists, or licensed mental health professionals. The title would require the Assistant Secretary to provide a list of peer review group members to Congress prior to awarding any grant, cooperative agreement, or contract reviewed by the group; and notify Congress 60 days before awarding any grant, cooperative agreement, or contract. The legislation would require at least half the members of each advisory council to be mental health care providers with experience in research or treatment and in the fields on which they are advising. While the inclusion of mental health provider perspectives on peer review groups and advisory councils seems reasonable, a rigid requirement for members with this expertise may not be feasible and may minimize the opportunity for important interdisciplinary perspectives. Requiring written notice to Congress before awarding any grants would be an atypical and overly burdensome task.

This title would require the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program to limit it activities and focus to abuse and neglect. This prevents the PAIMI program from protecting individuals with mental illness from other violations of their rights, such as housing discrimination. The legislation would prohibit any Protection and Advocacy System (P&A) receiving PAIMI funds from lobbying, including with private funds. The legislation would also prohibit a P&A from counseling an individual with a serious mental illness on their right to

refuse medical treatment and from acting against the wishes of the caregiver of an individual with severe mental illness. This title would require a P&A to ensure that caregivers of individuals with serious mental illness have access to their protected health information. Requiring a P&A to represent a caregiver could create a conflict of interest for the P&A, since their duty is to protect the individual with mental illness, and could require a P&A to divert its resources to helping caregivers and not individuals with mental illness.

I. TITLE IX – Reporting

This title would require a GAO report on compliance with the Mental Health Parity and Equity Addiction Act.

VI. SUMMARY-H.R. 2690, Including Families in Mental Health Recovery Act of 2015

Representative Matsui has introduced H.R. 2690, the Including Families in Mental Health Recovery Act of 2015. The legislation would clarify when providers may share protected health information, by instructing the Department of Health and Human Services (HHS) to promulgate regulations consistent with the February 2014 guidance issued by the HHS Office of Civil Rights. The bill also would provide $30 million to fund education and training to providers on HIPAA privacy rules and the guidance.

VII. WITNESSES

Creigh Deeds
Senator
Senate of Virginia

Patrick J. Kennedy
Former U.S. Representative (RI)
Founder
Kennedy Forum

Dr. Jeffrey A. Lieberman, M.D.
Chairman
Department of Psychiatry
Columbia University College of Physicians and Surgeons

Paul Gionfriddo
President and CEO
Mental Health America

Steve Coe
Chief Executive Officer
Community Access

Mary Jean Billingsley
Parent
National Disability Rights Network

Harvey Rosenthal
Executive Director
New York Association of Psychiatric Rehabilitation Services.