AGENDA: Public Policy Committee Meeting

June 18, 2020, 2:00 – 4:00 pm
Room: Virtual – Link will be provided by email

Thursday, June 18, 2020

2:00 pm **Welcome & Introductions**
Sara Howe, Chair, Public Policy Committee
Reyna Taylor, VP, Public Policy, National Council

2:05 pm **Election of Committee Vice Chair**
Alan Hartl, Chair of the Nominations Committee

2:10 pm **SUD Treatment Needs Post COVID: Policy changes made during COVID-19 to meet the growing populations – What should we advocate to keep?**
Reyna Taylor, VP, Public Policy, National Council

Focused discussion on:

- Understanding and prioritizing telehealth and other policy changes made during COVID to maintain post crisis. (Appendix A)
- Board consensus on related policy asks (Appendix B)

2:40 pm **COVID-related Stimulus Dollars & Legislative Actions**
Catherine Finley, Thorn Run Partners
Al Guida, Guide Consulting Services

Focused discussion on:

- General overview focused on the next COVID package, updates on draft iterations, and issues with funding disseminations
- Defining behavioral health providers

3:30 pm **Topics of National Concern**
Chuck Ingoglia, President & CEO, National Council

Focused discussion on:

- Climate-generated consciousness for behavioral health (Appendix C)
- Eliminating "Abuse" from the titles of federal agencies concerned with SUD (Appendix D)
- Ensuring racial justice efforts in advancing behavioral health (Appendix E)

4:00 pm Adjourn

APPENDIX A: How the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 and other agency-led policy changes have increased access to SUD treatment

Policy		Description	Resources
Coverage (CMS)	Medicare	An 1135 Waiver was issued by Health and Human Services for "requirements that physicians or other health care professionals hold licenses in the state in which they provide services if they have an equivalent license from another state." From March 6, 2020 until the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances. This will allow clinicians to provide a wider range of services without beneficiaries having to travel to a healthcare facility. Additionally CMS released an interim final rule released on March 30. Summary of key provisions can be found here and CMS released a list of FAQs. On April 30, CMS issued another interim final rule which added additional flexibilities, including for audio-only services.	Medicare telehealth coverage policies during COVID-19 (table) CMS FAQ on Medicare FFS billing
	Medicaid	CMS offers states broad flexibility to cover telehealth using various methods of communication including audio-only, telephonic, video technology commonly available on smart phones and other devices. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. States are issuing new guidance and initiating changes that include but are not limited to the following: • Allowing providers who do not have access to the technology required for video enabled virtual session to provide telephonic (i.e., audio-only) sessions; • Waiving face-to-face requirements to allow for services in programs such as health homes or care coordination programs; • Temporarily waiving requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have an equivalent licensing in another state; • Permitting providers located out of state to provide care to another state's Medicaid enrollees impacted by the emergency; and • Temporarily suspending certain provider enrollment and revalidation requirements to increase access to care.	CMS Medicaid Telehealth Guidance to States Federation of State Medical Board Licensure Changes

Prescribing (SAMHSA & DEA)	**Methadone (OTP)**	On March 19, SAMHSA issued updated OTP guidance indicating that states may request blanket exceptions for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder. That OTP guidance also notes that states may request up to 14 days of Take-Home medication for those patients who are less stable but who the OTP believes can safely handle this level of Take-Home medication. New patients being admitted to an OTP for OUD must receive a physical face-to-face evaluation if they are going to be treated with methadone. This exemption will last for the duration of the declared COVID-19 national emergency. Practitioners working in OTPs can continue treating existing patients with methadone and buprenorphine via telehealth (including use of telephone, if needed). An OTP can dispense medication (either methadone or buprenorphine products) based on telehealth evaluation (including telephone, if needed).	FAQs: Provision of Methadone and Buprenorphine for the Treatment of OUD in the COVID-19 Emergency DEA State Separate Requirement Policy Exception
	Buprenorphine (OBOT)	SAMHSA exempted OTPs from the requirement to perform a physical face-to-face evaluation for any new OTP patient who will be treated with buprenorphine. In other settings (e.g., OBOTs), DEA-registered providers may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met: • The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice • The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system. The practitioner is acting in accordance with applicable Federal and State law. Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy.	

Privacy (HHS & SAMHSA)	**HIPAA**	HHS Office of Civil Rights (OCR) issued a "Notification of Enforcement Discretion" for telehealth during the COVID-19 national public health emergency. HHS will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth services during the COVID-19 nationwide public health emergency. Covered health care providers can use any product that is available to communicate with patients (e.g., Facebook Messenger, Google Hangouts, or Skype). States may have their own laws and regulations regarding protected health information and what is required to protect and secure it. This federal action does not explicitly address state enforcement of those state laws and regulations.	FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency
	42 CFR part 2	SAMHSA issued guidance related to use and disclosure of confidential information in cases of a medical emergency. SAMHSA's guidance emphasizes that under this medical emergency exception, "providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients. SAMHSA advises: **1.** Patient identifying information may be disclosed by a part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained; and, **2.** Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed.	COVID 42 CFR part 2 Guidance from SAMHSA

The Federal Communications Commission (FCC) established a $200m COVID-19 Telehealth Program which allows eligible providers including community mental health and substance use organizations to apply for grants to fund technology and equipment to bolster service delivery via telehealth.

APPENDIX B: Request for public policy committee approval:

Restrictions on opioid use disorder (OUD) treatment with methadone and buprenorphine have been reduced temporarily (i.e., until the end of COVID-19 public health emergency). The National Council requests a vote from the public policy committee to advocate that after the public health emergency, the federal government should:

A. Revert to previous treatment policies
B. Permanently continue treatment policies
C. Abstain from the discussion

1. **Opioid treatment providers (OTP):** State may request blanket exceptions for all stable patients in an OTP to receive up to 28 days of take-home doses of methadone for the treatment of OUD and up to 14 days of take-home doses for less stable patients. New patients require a face-to-face evaluation, but all other patients may be treated with video and audio-only telehealth.

    A. Revert to previous treatment policies
    B. Permanently continue treatment policies
    C. Abstain from the discussion

2. **Office-based opioid treatment (OBOT):** DEA-waivered providers may issue a prescription electronically for schedules II-V (buprenorphine is schedule III), for current and new patients. *Note: This policy would become permanent through the Mainstreaming Addiction Treatment Act, which eliminates the need for the x-waiver for buprenorphine to treat patients.*

    A. Revert to previous treatment policies
    B. Permanently continue treatment policies
    C. Abstain from the discussion

3. **HIPAA:** Medicaid- and Medicare-covered providers can use less secure technology platforms (e.g., Facebook Messenger, Google Hangout, Apple iPhone FaceTime) and audio-only technologies (i.e., landline and mobile telephones) for visits.

    A. Revert to previous treatment policies
    B. Permanently continue treatment policies
    C. Abstain from the discussion

APPENDIX C: Climate-generated consciousness for behavioral health

Why the Need to Enact a Climate Mental Wellness and Resilience Policy? The International Transformational Resilience Coalition (ITRC) seeks organizational and individual endorsements for its new *Climate Change Mental Wellness and Resilience Policy*.

The policy is urgently needed at the local, state, and federal levels because global temperatures will, in the not too distant future, rise above the 2.7 F (1.5C) temperature threshold scientists say will greatly accelerate destructive climate impacts. Left unaddressed, the more frequent and extreme disasters that will be intermixed with continual cascading disruptions to the ecological, social, and economic systems people rely on for food, water, incomes, and other basic needs will produce mental health and psycho-social-spiritual problems far beyond anything modern society has ever experienced.

The harmful psychological, emotional, and behavioral reactions to climate impacts will profoundly affect daily functioning, and threaten everyone's health, safety, and wellbeing. They will also cause people to withdraw into a self-protective survival mode that makes it very difficult to do what is needed to reduce the climate emergency to manageable levels.

For years, the U.S. mental health system has been dysfunctional. It also primarily focuses on treating individual disorders, not building community-wide capacity to prevent them. Clinical therapy and direct service programs, while very important, will therefore not be able to help millions of people prevent or heal from the coming tsunami of climate-generated mental health and psycho-social-spiritual problems. New thinking and new approaches are urgently needed to 'future-proof' psychological and emotional wellbeing.

The New ITRC Climate Change Mental Wellness and Resilience Policy

The ITRC policy calls for the establishment of community-centered initiatives nationwide to build population-level mental wellness and resilience for a wide range of climate change-generated traumas and toxic stresses. The enabling infrastructure of the new approach is the formation of a Resilience Coordinating Council (RCC) in every community or region. Its purpose is to bring together a diverse set of uncommon partners to co-create innovative age and culturally appropriate actions that teach everyone mental wellness and resilience information and skills, establish and connect quality social support networks, transform unhealthy norms, build group and community strengths, and construct a local culture that enables people to safely overcome distress and find meaning, purpose, and hope in the midst of ongoing climate adversities. The RCC should work closely with and refer people who experience severe disorders to behavioral health programs.

The tools and methods involved with building mental wellness and resilience were developed for non-climate related psychological and emotional traumas. The new policy will therefore help prevent and heal many types of mental health and psycho-social-spiritual problems beyond those generated by the climate emergency.

APPENDIX D: Eliminating "Abuse" from the titles of federal agencies concerned with SUD

Dr. John Kelly of Harvard Medical School and Massachusetts General Hospital has approached National Council about cosigning a letter to change the names of federal institutes on addiction. The letter proposes removing the term "abuse" from the National Institutes of Health and related federal administrations pertaining to addiction and replacing the term with non-stigmatizing terminology. Committee members were in support of the letter and agreed on the need to remove "abuse" from federal institutes on addiction. Similar state initiatives, as well as alternative naming conventions were discussed. The Public Policy committee will vote at the June meeting on National Council's next steps regarding Dr. Kelly's letter.

The Health Policy Committee of the Society of Behavioral Medicine (SBM) developed a very concise policy brief that advocates for the removal of the term "abuse" from the National Institutes of Health and related federal administrations (e.g., SAMHSA) pertaining to addiction and replacement with more neutral and non-stigmatizing terminology (e.g., disorder). there is now a strong empirical rationale relating to stigma and discrimination for removing the "abuse" terminology.

For board approval, the National Council on Behavioral Health in particular is interested in endorsing this brief given the organization's dedication to reducing stigma and discrimination against individuals who are suffering, or are in remission, from alcohol and other drug use disorders. A federal act of congress is required to change names of National Institutes of Health and related federal institutions (e.g., SAMHSA). The current names have been in place since 1970 (NIAAA), 1974 (NIDA), and 1992 (SAMHSA/CSAT). Different legislation was passed to name these institutes at the time of their formation.

- In the case of NIAAA, for example (1970), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (aka the Hughes act) marked its naming and founding.
- In 1974, NIDA was established as part of the "Alcohol, Drug Abuse, and Mental Health Administration" (ADAMHA) and later in 1992 became part of the NIH.
- SAMHSA was established in 1992 by Congress as part of a reorganization of the Federal administration of mental health services. A new law renamed the former ADAMHA to SAMHSA. One of the subsidiary centers of SAMHSA, is the Center for Substance Abuse Treatment (CSAT), intended to administer block grant funding for "substance abuse".

At the time of the forming and naming of these institutes, there was little debate or opposition to these organizations' names as they were deemed fitting for that specific era – now up to 50 years ago.

Recommendation #1 (One sentence maximum):

- Congress must act to change the names of the National Institutes of Health on addiction (i.e., NIAAA; NIDA) and related federal institutions (SAMHSA; CSAT)

Recommendation #2 (One sentence maximum):

- Alternative names for the federal organizations that SBM supports are the "National Institute on Alcohol Use Disorder", the "National Institute on Drug Use Disorders", the "Substance Use Disorder and Mental Health Services Administration", and the "Center for Substance Use Disorder Treatment."

APPENDIX E: Ensuring racial justice efforts in advancing behavioral health

Chuck's statement on the death of George Floyd:

I try very hard to keep my daily updates quick, intellectually simple and easy to digest. But I can't do that today.

It's important to me, to the ELT and to our Diversity and Inclusion Committee that we stand up today and express our profound sadness and fury over the events in Minneapolis, Minnesota.

First of all, you may know already that the ELT posted this statement today on our website, and we will share it on our social platforms.

In addition to that external statement, it's very important that we let all of you know where we stand.

In no uncertain terms, the National Council is appalled by the murder of George Floyd and the response by the city of Minneapolis to protests over the blatant police brutality that led to his death. The pattern of police abuse in this country is nauseating. The pattern of police abuse against black Americans is shameful.

Racism, police brutality and the absence of social justice leave deep scars on people and communities. They destroy trust among each other. They erode confidence in our institutions. And they fracture our mental health by increasing anxiety, raising fears and deepening depression.

We must do better as a nation, and we can do better as an organization.

That's why it's important that we do more than express outrage, and I want you to know that your ideas on important issues of social justice and racism are most welcome at the National Council.

The Diversity and Inclusion Committee was created to provide a forum for all of us to share ideas, concerns and strategies to address issues surrounding racism. To that end, the Diversity and Inclusion Committee co-chairs will extend an invitation to participate in upcoming conversations over lunch. I encourage you to participate in these open dialogues, but participation is not mandatory.

We will benefit greatly by having these conversations.

We will benefit by listening to each other.

And we will benefit by remembering the tragic stories of George Floyd in Minneapolis, Ahmaud Arbery in Georgia, Sandra Bland in Texas, and Breonna Taylor in Kentucky.

Thank you. Be safe.