STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

CHRISTOPHER T. SUNUNU
Governor

January 17, 2018

The Honorable Lamar Alexander, Chairman
The Honorable Patricia Murray, Ranking Member
Committee on Health Education, Labor & Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

Thank you for seeking input from states on what further changes to federal law or regulations would be helpful in combatting the opioid crisis. As you may know, the Centers for Disease Control and Prevention recently reported that in 2016 New Hampshire experienced the third highest rate of opioid related deaths in the nation. Of the 50,000 new adult group members currently enrolled in the New Hampshire Health Protection Program, over 6,000 unique individuals per month are receiving substance misuse disorder services. Over eighty percent of the state's prison population suffers from co-occurring mental health and substance misuse disorder illnesses.

New Hampshire has found federal assistance to be valuable in addressing this public health crisis. A central part of the state's response has been the increased access to treatment resources in the state through expansion of behavioral health benefits in Medicaid as well as by commercial carriers on the Federal Marketplace, including for the New Adult Medicaid group.

The New Hampshire Insurance Department has benefited from federal Consumer Protection and Enforcement grant funding which, in combination with participating in the Substance Abuse and Mental Health Services Administration (SAMHSA) commercial parity academy, has bolstered our ability to enforce insurance laws that provide access to behavioral health services, including treatment for substance use disorders (SUD). In particular, we have been able to conduct market conduct examinations that look at insurance companies' conduct in complying with laws that protect consumers, particularly mental health parity laws. The Parity Academy also enhanced our ability to conduct outreach and education and to better understand how to enforce the non-quantitative treatment limitations in the parity law.

At the same time, inadequate funding and unnecessary constraints have limited our ability to use federal resources in the ways that would be most helpful in New Hampshire. We offer the following recommendations for changes in law and/or policy that would assist in our state's response to the opioid crisis:

1. **Address Shortcoming of Cures Act**: In its previous iteration, Cures Act Funding did not adequately or appropriately address the disproportionality of the opioid epidemic on a state by state basis. As a result of using a population based funding mechanism, New Hampshire, which has the 2nd highest level of opioid related deaths in the nation (39 Deaths/100k), received the same funds per capita as Nebraska (6.4 Deaths/100k). By disregarding the disproportionate distribution of the opioid epidemic across the country, the last Cures Act disadvantaged states that have epidemiologically demonstrated need. Ignoring population based need has resulted in

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Cures Act funding being distributed to states that are struggling to spend these funds within Cures Act guidelines, while other states, like New Hampshire, continue to experience unprecedented need for resource and assistance. Thank you for providing this opportunity for New Hampshire to articulate its argument that it is essential that the next version of The Cures Act correct this miscalculation and afford New Hampshire its fair share of Federal Resource as we continue our struggle to overcome the Opioid Epidemic in the Granite State.

2. **Review and Adjustment of the SAMSHA SUD Block Grant Award**: It has been over 10 years since New Hampshire's block grant allocation for substance misuse from SAMHSA has been reviewed and adjusted, despite the need for increased resources to combat the opioid crisis. In order to more effectively increase capacity for treatment, SAMHSA should consider relaxing federal regulations that currently prohibit the use of its block grant funds for capital expenditures that would significantly increase the number of available treatment beds. Additional flexibility in the use of the block grant should include the following:
    a. **Prevention:** Provide additional funding for harm reduction programs (like needle exchanges) and for early childhood prevention services.
    b. **Treatment**: Cover construction and renovation costs for SUD treatment facilities, as well as allowing SAMSHA funds to cover services and programs that support recovery but are outside the standard parameters for treatment, or that are provided by different types of providers.
    c. **Recovery**: Allow block grant funds to be used for recovery housing.
    d. **Administrative, Policy, and Technical**: Allow flexibility on the use of funding for systems analysis and administrative expenses, so the state can better tailor its use of the funds to support the areas of greatest state need.

3. **IMD Exclusion**: Although the Centers for Medicare and Medicaid Services (CMS) has relaxed the application of the Institutes for Mental Disease (IMD) Exclusion to allow Medicaid reimbursement for SUD services at in-patient facilities with more than 16 beds for up to 30 days with a Section 1115 waiver, the continued inclusion of SUD services within the IMD Exclusion inhibits the establishment of new cost effective treatment facilities and it is inconsistent with the legislative history of the federal Medicaid statute. The IMD Exclusion was intended to prevent the transfer of state costs to the federal government for the operation of large public mental health hospitals before deinstitutionalization and the establishment of community based mental health treatment in the United States.

4. **Clarification of 42 CFR Part 2**. This regulation, while intended to protect privacy, constrains information sharing between providers in integrated settings. We recommend changes to make disclosure of substance use records easier for purposes of care integration, and also for purposes of claims data reporting, which is integral to states' ability to understand trends in the delivery of care and craft appropriate policy approaches.

Thank you again for the opportunity to offer input on this important issue.

Sincerely,

Christopher T. Sununu
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