

State Legislation:

ABLE Act: Assembly Bill 731 –gives Wisconsin residents access to ABLE accounts sooner, and with a greater variety of options than if Wisconsin had developed its own state-specific ABLE program. Without the passage of AB 731, Wisconsin citizens would have waited until at least 2017 before being able to open an ABLE Act account. A recent change to state residency requirements under the federal ABLE law means a Wisconsin resident can open an account anywhere in the country where an ABLE program is offered. This will allow comparison shopping for the best program to fit a person's needs.

Wisconsin Promise Financial Coaches can help with the financial questions families may have about ABLE Accounts, and Wisconsin Promise Benefit Specialists can help with benefits related questions about ABLE Accounts. For more information, please see the following FAQ:

<http://legis.wisconsin.gov/assembly/88/macco/able-explanation-and-faqs/>

Once we know of a state who has available ABLE Accounts, we will make sure to let everyone know.

Ellie Hartman, Ph.D, BCBA-D
Wisconsin PROMISE Grant Project Manager
Division of Vocational Rehabilitation (DVR),
Department of Workforce Development (DWD)
201 East Washington., Rm G100
Madison, WI 53707

SB 166 Adds “employment status” among the list of unfair discrimination:

SECTION 1. 111.31 (1) of the statutes is amended to read: **SB166,3,42** 111.31 (1) The legislature finds that the practice of unfair discrimination in employment against properly qualified individuals by reason of their age, race, creed, color, disability, marital status, sex, national origin, ancestry, sexual orientation, arrest record, conviction record, employment status, military service, use or nonuse of lawful products off the employer's premises during nonworking hours, or declining to attend a meeting or to participate in any communication about religious matters or political matters, substantially and adversely affects the general welfare of the state. Employers, labor organizations, employment agencies, and licensing agencies that deny employment opportunities and discriminate in employment against properly qualified individuals solely because of their age, race, creed, color, disability, marital status, sex, national origin, ancestry, sexual orientation, arrest record, conviction record, employment status, military service...

SB 352 Amends current sick leave which affects those using Family and Medical Leave. Go to <http://docs.legis.wisconsin.gov/2015/related/proposals/sb352>

SB 385 This bill expands the family and medical leave law to permit an employee covered under that law to take family leave to care for a grandparent, grandchild, or sibling, lowers the threshold number of employees above which an employer must permit an employee to take family or medical leave, and establishes a family and medical leave insurance program under which certain covered individuals may receive benefits while taking family or medical leave. Go to <http://docs.legis.wisconsin.gov/2015/related/proposals/sb385>

Federal Legislation:

HR 2646, the Helping Families in Mental Health Crises Act of 2015

S 1945 is the Senate version that is not identical but similar.

The Wisconsin Council on Mental Health (WCMH) is the statutorily-mandated Governor-appointed state advisory council on mental health for the state of Wisconsin. Our role is to advise the Governor, Legislature and state agencies on funding and policy decisions related to mental health. From time to time we will also contact Congress about federal bills that could significantly impact mental health policy and funding in Wisconsin. We did so last year in response to Rep. Tim Murphy's bill, HR3717, the Helping Families in Mental Health Crisis Act of 2013. Previously we have urged Wisconsin's Congressional delegation to oppose that bill for a variety of reasons, largely because of the manner in which it incentivized use of involuntary treatment, reduced the rights of people with mental illnesses and moved away from the model of recovery and consumer involvement that has transformed mental health services in the past 20 years.

Earlier this year Rep. Murphy and Rep. Eddie Bernice Johnson introduced HR2646, The Helping Families in Mental Health Crisis Act of 2015. Since that time the bill has been marked up and approved by the Health Subcommittee of the House Committee on Energy and Commerce. While this letter references HR2646 another comprehensive mental health reform bill—S1945—has been introduced in the Senate by Sen. Bill Cassidy and Sen. Christopher Murphy. While the Senate bill is not identical to the House bill, we have not been able to do the same type of analysis on S1945 as we have done on HR2646. However, there is overlap between the bills. We ask that Wisconsin's United States Senators be cognizant of the issues identified below as they review that bill.

Some advocacy groups have noted some positive changes from last year's bill, both as the bill was introduced and in the mark-up. This may have served to suggest to Members that the bill is now acceptable to the mental health community. In our opinion this is not the case.

Unfortunately the bill continues to undermine the advances we have made in this country on consumer and family empowerment, the recovery philosophy and the rights of individuals with mental health disorders. As a result we urge you to oppose this legislation. Some of the specific concerns we continue to have with the bill include:

1. The bill continues to incentivize assisted outpatient treatment (AOT), although instead of penalizing states that don't have such laws, as last year's bill did, the legislation will reward those states that do by an increase in the federal mental health block grant (MHBG). While "assisted outpatient treatment" sounds benign and helpful what it really means is involuntary treatment—assistance whether you want it or not. The existence of involuntary treatment often acts as a deterrent for individuals to seek treatment, either prior to or subsequent to being subject to involuntary commitment. Additionally, involuntary treatment cannot work if money is not made available for services for such individuals. But it is not clear that we couldn't increase the number of people voluntarily receiving services if we made more funds available for treatment options that are acceptable to individuals with mental illnesses. And these include the very recovery services that may be jeopardized by this legislation.

It is unclear to us whether the incentive funds represent an increase in the total allocation for the MHBG. If it does not, that means that states that don't receive the incentive will be cut. At this point it is difficult to determine whether Wisconsin's laws would qualify us as a state with AOT laws. If not, we could see a reduction in our MHBG funds.

2. The bill continues to restrict the activities of the agencies implementing Protection and Advocacy for Individuals with Mental Illness (PAIMI); in Wisconsin this is Disability Rights Wisconsin. While the limitations are not as severe as in the original bill the legislation would still limit PAIMI activities to concerns around abuse and neglect of such individuals. However these agencies do so much more that we think is critical for persons living with mental illnesses including addressing the right to be free from discrimination in employment, housing and other areas; the right to appropriate treatment in integrated settings; the right to access benefits in the least restrictive environment. They also do significant work keeping kids with mental health needs from being expelled for behaviors related to their disability.
3. The bill treats privacy and confidentiality for people with psychiatric disability ("serious mental illness") under the Health Insurance Portability and Accountability Act (HIPAA) differently than for other patients. Although the Energy and Commerce Health Subcommittee adopted an amendment to require the appropriate federal agencies to codify existing guidance provided about communications related to persons with mental illnesses under HIPAA and support training of providers around what is allowed under HIPAA, the bill still appears to add new regulatory requirements applicable only to people with psychiatric disability.

There are also implications in the bill for the Family Educational Rights and Privacy Act (FERPA). These will be of most interest to those of you who sit on House Education and Workforce Committee.

FERPA generally conditions federal funds upon agencies and schools granting access to educational records to parents of minor or dependent students or to adult students and keeping those records confidential. It allows confidentiality to be waived and records released with consent. FERPA also allows records to be disclosed under other circumstances, including under an emergency. These regulations already allow an agency or institution to: "disclose personally identifiable information from an education record to appropriate parties, including parents of an eligible student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals."

HR2646 allows certain information to be released to caregivers without the consent of the student if a physician, psychologist, or other recognized health professional or paraprofessional acting in his or her professional or paraprofessional capacity, or assisting in that capacity reasonably believes such disclosure to the caregiver is necessary to protect the health, safety, or welfare of such student or the safety of one or more other individuals.

This language allows this type of disclosure in any situation—not just an emergency. It seems that such a disclosure would violate the professional ethics of a physician or psychologist under any situation covered by the new language where the threat is not imminent.

We remain concerned that overall the bill retains a bias towards the medical model and against the involvement of consumers and family members in policy development and oversight. We have seen the transformation that has occurred through the inclusion of people living with mental illnesses and their family members in both the development of policy and the implementation of programming. Wisconsin has been out in front of the movement to include peers as providers, a model which can make services more acceptable to those living with

mental illnesses. This movement promises to engage individuals who have been reluctant or often afraid, to engage with the traditional mental health system due to the very coercive interventions that HR2646 would support. Unfortunately, HR 2646 puts adult peer support and family-driven, parent-peer programming at risk. People living with mental illnesses and families of children and youth with mental health issues need a full spectrum of services, supports and treatment options, but the bill's definition of "evidence-based" prioritizes medical intervention to the potential exclusion of effective supportive services. This, coupled with the proposal to reorganize the Substance Abuse and Mental Health Services Administration (SAMHSA), jeopardizes successful but non-medical grant programs such as the Statewide Family Network grant program and the Statewide Consumer Network grant program. Decision-making authority regarding what constitutes evidence-based practice would be skewed toward the medical community, without the benefit of input from the very people who utilize such services and can provide valuable insight into what really works.

Furthermore, the bill incorporates a fundamental misunderstanding of peer support, and parent-peer support by extension. The peer and parent-peer relationship relies upon the trust that comes from bringing an independent voice to the conversation. HR 2646, in contrast, undermines that trust by defining peer support to require supervision by a licensed treatment professional, and requiring that peer support specialists be "in treatment" rather than recognizing the full spectrum of recovery experiences. Placing such limitations upon the definition of peer support would turn the clock back by decades on the continuing successes of peer-run and family-run organizations.

There are also significant questions and concerns about the cost of this legislation. The Congressional Budget Office notes that without language requiring the Chief Actuary at the Center for Medicare and Medicaid Services to certify that the provisions of the bill would not increase costs to these programs the cost to the federal government could be up to \$66 billion in the period of 2016-2025. It appears that the bulk of this increase would be due to allowing federal Medicaid reimbursement for services provided to individuals in Institutions of Mental Disease. We have concerns that this expansion could lead to increased rates of hospitalization at the expense of using funds to enhance community-based services for individuals with mental illnesses. Even excluding provisions that would lead to increased Medicaid and Medicare costs the spending is estimated at up to \$3 billion for the period of 2016-2024.

As the bill continues to move through the Congress please feel free to contact us should you have questions about proposed modifications to the legislation. While we understand that there are many aspects of the bill that are viewed as positive by various groups, the items identified above are among the most concerning aspects of the bill that make it impossible for us to support the legislation.

Competitive Bidding

Medicare DMEPOS Competitive Bidding Improvement Act of 2015 (H.R. 284; S. 148).

Ensuring Access to Quality Complex Rehabilitation Technology Act of 2015 (H.R. 1516; S. 1013).

The Centers for Medicare and Medicaid Services (CMS) created the Competitive Bidding program for purchasing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). The program establishes rates for certain categories of equipment, but it does not require vendors to fulfill their contracts. It was intended to cut costs and reduce billing discrepancies. It has instead resulted in a lack of local providers and delays in deliveries, which have lengthened hospital stays and driven costs up.

Critically missing is an independent evaluation of the program's impact on beneficiary health. NCIL believes a full review of the program should be available before the program expands nationally to avoid preventing people with disabilities from having access to vendors of critically needed supplies, especially in rural areas.

Because of the problems we have already seen, NCIL has supported a number of measures aimed at ending the CMS Competitive Bidding program, and supports similar measures in this Congress. Such legislation can help eliminate the dangers created by this program, but it will never pass unless members of the House and Senate understand that the program is actually reducing access and support for their constituents with disabilities. Consequently, NCIL supports the *Medicare DMEPOS Competitive Bidding Improvement Act of 2015 (H.R. 284; S. 148)*.

Additionally, Medicare currently does not have unique coverage for the more complex needs of individuals with disabilities and chronic medical conditions that require medically necessary individually configured products and services. We believe the creation of a separate recognition of CRT will result in decreased Medicare expenditures by averting hospitalizations due to conditions such as severe pressure sores and blood clots. In the interest of quality healthcare and optimal functionality for individuals with disabilities and chronic medical conditions, recognition of a separate category for CRT is needed, so NCIL supports the *Ensuring Access to Quality Complex Rehabilitation Technology Act of 2015 (H.R. 1516; S. 1013)*.

Keeping All Students Safe Act, HR 1893, a bill to protect all students nationwide from restraint and seclusion was recently introduced by Congressman Gregg Harper (R-MS)

NCIL strongly supports legislation to end restraint and seclusion and we know our members do, too. Please take this opportunity to contact your Representative and ask them to co-sponsor and support the Keeping All Students Safe Act, HR 1893.

For more information go to:

<http://www.advocacymonitor.com/action-alert-ask-your-representatives-to-co-sponsor-and-support-newly-introduced-restraint-seclusion-legislation-in-the-house-of-representatives/>

