American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

February 16, 2018

The Honorable Orrin G. Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
Senate Committee on Finance
United States Senate
Washington, DC 20510-6200

Transmitted via email: Opioids@finance.senate.gov

Re: Request for Recommendations for Policy Actions to Address the Opioid Epidemic

Dear Chairman Hatch and Ranking Member Wyden:

As the nation continues to struggle with the devastating public health crisis created by the opioid epidemic, it is encouraging to see the Senate Finance Committee exploring how changes in public policy and the Medicare and Medicaid programs can help in the fight. We appreciate your interest and commitment and welcome this opportunity to continue to work with you. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,00 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for addressing the nation's opioid epidemic.

HOSPITALS AND HEALTH SYSTEMS ARE ALREADY TAKING ACTION

Every day, hospitals witness the devastating effects of the opioid epidemic on the patients, families, and communities we serve. Prescription opioids can be a safe and necessary element of pain management for those who have experienced trauma or are suffering from cancer, sickle cell disease or other diseases that cause debilitating pain. On the other hand, opioids carry significant risk for misuse, addiction, overdose and death, and must be used judiciously.

To prevent addiction and misuse, hospitals and health systems are working to reduce patients' exposure to opioids by making other types of pain control more readily available. They are implementing standard, evidence-based protocols for prescribing limited amounts of opioids to patients, and they are safeguarding prescription drugs from diversion. Our members are using state prescription drug monitoring programs and working to link them to their electronic health

records (EHRs) to ensure that a seamless and accurate flow of information regarding the patient's prescriptions is available.

When patients are diagnosed with substance use disorder (SUD), hospitals are offering treatment or referrals, as appropriate, and integrating physical and behavioral health care. They are training first responders to use naloxone and, in some cases, equipping them with this overdose antidote.

However, hospitals are aware that this epidemic cannot be successfully dealt with by health care providers working independently. They are collaborating with their communities to create coordinated responses. They are forming partnerships with other health care providers, state and local departments of health, law enforcement, schools, community organizations and others. Through these collaborations, we have seen hospitals engage recovery specialists to help patients admitted for drug overdose enter treatment, expand SUD treatment services, join with law enforcement to facilitate access to treatment, fund public education programs, educate community clinicians about prescribing practices, and more. But much remains to be done.

There are five policy issues of paramount importance to enable this work to address opioids to continue.

1) Preserve and Protect Health Insurance Coverage, Including Medicaid. We urge the Committee to ensure that coverage through the health insurance exchanges and through Medicaid, which provide a substantial number of Americans with benefits for substance use disorder treatment, be preserved. In addition, the Senate Finance Committee has the opportunity to ensure that Medicaid programs adequately cover SUD treatment, and an essential step in that effort is to eliminate the Institutions for Mental Disease (IMD) exclusion. This exclusion prohibits Medicaid from paying for care for patients between ages 21 and 64 who are hospitalized in inpatient psychiatric hospitals, thus making it extremely challenging for those of limited means to receive effective treatment for substance use disorders. Prohibiting payment for SUD treatment in freestanding psychiatric facilities seems to further stigmatize and blame victims for their illness.

IMDs could expand access to services for patients with SUDs if the exclusion were eliminated. Addressing this exclusion would be particularly helpful in improving access to treatment for those with severe or more complex SUDs. It also could reduce wait times, and possibly the occurrence of emergency department boarding, for patients with both substance use and mental health disorders who would benefit from inpatient treatment. **We urge the Committee to report out legislation to end the IMD exclusion.**

2) Enhance Parity Enforcement. The Mental Health Parity and Addiction Equity Act (MHPAEA) gave the Department of Labor responsibility for enforcing parity in health coverage. Our members and the patients they serve continue to face obstacles in securing coverage and payment as intended by the parity law. More must be done to enhance parity compliance, including ensuring that parity provisions included in the 21st Century Cures Act are carried out. New guidance for health plans, improved transparency of benefit information, and additional parity compliance analysis tools can all support better adherence to MHPAEA provisions.

Federal agencies, and especially the Department of Labor, must make parity enforcement a priority. **We urge the Committee to clearly communicate this expectation to the Secretary of Labor**.

3) Make Critical Information Readily Available to All Clinicians Treating Patients with SUD. Clinicians treating patients, for any condition, need information on their substance use disorder to ensure their patients' safety. The partitioning of a patient's medical record to keep SUD diagnoses and treatments hidden from most clinicians who will treat the patient is dangerous for the patient, burdensome for providers and contributes to the stigmatization of mental/behavioral health diseases. Too many patients who suffer from an SUD have stories of how a well-intentioned emergency room physician or other clinician working on physical health issues nearly prescribed them an opioid or another drug that would have endangered their life or sobriety. Such incidents happen because the clinician cannot access information on the patient's SUD and treatment plan unless the patient gives consent. The prevalence of SUD in the population requires that hospitals have access to complete information about the patient's medical history, including information about substance use disorders.

Finally, providers go to extraordinary lengths to comply with the requirements of 42CFR Part 2. For example, we have spoken to obstetricians who specialize in treating pregnant women with SUD diagnoses and other clinicians who treat both the physical and SUD diagnoses of patients. To ensure compliance with 42CFR Part 2, as currently written, these clinicians have to have two separate computers and two separate medical records. This adds burden and expense, with no benefit to patients.

Recent revisions made by the Substance Abuse and Mental Health Services Administration to the Part 2 regulations are not a significant improvement over the previous requirements and do little to eliminate the regulation's barriers that impede the robust sharing of patient information necessary for effective clinical integration and quality improvement. Complete alignment of Part 2 with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule will require statutory changes. **We urge the members of the Committee to support S. 1850, the Protecting Jessica Grubb's Legacy Act, introduced by Sens. Joe Manchin (D-WV) and Shelley Moore Capito (R-WV), which would mandate that 42 CFR Part 2 be brought into alignment with HIPAA. This alignment would protect patients from inappropriate disclosure of their health information while enabling clinicians to more safely treat those with SUD**. Further, while that bill is under consideration, we urge the Committee to encourage the Centers for Medicare & Medicaid Services to include information for beneficiaries in the Medicare & You handbook and in public service announcements to alert patients and their families that clinicians other than those caring for behavioral health issues will not be able to access information about their prescriptions or treatment plan for SUD without their express permission, and explain why it is important for the patients' safety that their clinicians know about their diagnoses.

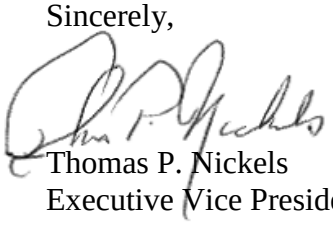
4) Enhance Medication-assisted Treatment (MAT). A recent report from the National Academies of Sciences, Engineering and Medicine underscores the gaps in availability of MAT in the U.S. The AHA has previously supported efforts to increase patient limits for

buprenorphine prescribing. The federal government should continue to incentivize adequate access to MAT. That starts with having enough clinicians with specialized training. Among the key challenges for health systems in offering SUD services is finding trained providers. Medicare should incentivize providers to get this training by providing an increase in payment to those who have completed the training or by recognizing the acquisition of such skills as a quality improvement activity under the Merit-based Incentive Payment System.

5) Promote Interstate Data Sharing Among Prescription Drug Monitoring Programs (PDMPs). The AHA also supports efforts to ensure that PDMP information is shared across state lines. State PDMPs are an important tool in fighting the epidemic, and Congress should seek ways to maximize the capacity of this technology to help clinicians avoid unnecessary or potentially harmful opioid prescriptions. We understand that most PDMPs already engage in some level of information sharing, especially with their neighboring states. To enhance these efforts, certified EHRs can be used to improve knowledge about a patient's medications – active and prior. The best approach would be to ensure the inclusion of PDMP information in the certified EHR in a timely and efficient manner in the course of the clinical workflow, which requires improved interoperability. **We urge the Committee to consider dedicated funding to promote improved interoperability between health care providers and PDMPs, and among PDMPs in different states.**

Thank you for this opportunity to comment. If you have questions or need further information, please feel free to contact me or have a member of the Committee staff reach out to Priscilla Ross, senior associate director of federal relations, at pross@aha.org or 202-626-2677.

Sincerely,



Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy