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104 Hart Senate Office Building  
Washington, DC 20510

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Senate Finance Committee  
221 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Hatch and Senator Wyden:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing more than 37,800 psychiatric physicians nationwide, we write to thank you and the Senate Finance Committee for your recent letter requesting feedback from stakeholders as to the current opioid addiction epidemic. As front-line physicians who treat patients with substance use disorders every day, we are concerned about the impact the crisis is having on patients, families, and communities.

According to the National Survey on Drug Use and Health, in 2016 about 19.9 million adults needed substance use disorder (SUD) treatment, yet only 2.1 million received specialty treatment. One primary reasons for this “treatment gap” is that many individuals lack health care coverage and cannot afford treatment. To turn the tide on this epidemic, we need to improve access to effective evidence-based treatment, reduce the stigma associated with substance use disorders, and protect safety net programs that offer valuable coverage for individuals and families in need of treatment.

We appreciate the Committee’s attention to this important issue and are pleased to offer the following recommendations.

**How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for opioid use disorder OUD and other SUDs to improve patient outcomes?**

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### *Coverage of Medication Assisted Treatment*

Despite the proven success of medications such as buprenorphine to treat OUD and other SUDs, several states currently do not reimburse for medication-assisted treatment (MAT)-related services through their Medicaid plans. **We urge you to support efforts to reclassify all FDA approved and evidence-based forms of MAT as a “mandatory service” that all state Medicaid plans must cover.** In addition, Medicare has no comprehensive SUD treatment benefit, including reimbursement for services delivered or drugs dispensed by an opioid treatment program. Likewise, **we urge the development of a National Coverage Determination for MAT-related services that would provide guidance to local contractors and set clear coverage guidelines and policies for providers and beneficiaries alike.**

### *Parity of Coverage and Reimbursement*

Nearly ten years after the enactment of the Mental Health Parity and Addiction Equity Act, providers of mental health and OUD services continue to experience disparities in reimbursement, and patients experience disparities in coverage for these same services. According to a report released last December, insurers in 46 states and the District of Columbia offered plans with higher rates for primary care office visits than for behavioral health office visits, while patients seeking behavioral health services were four times more likely to receive treatment from out-of-network providers than those seeking medical or surgical services. **We recommend the Committee encourage CMS to increase reimbursement for substance use disorder services to be at parity with other health services.**

### *Prior Authorization*

The process of obtaining prior authorization for services and/or dispensing of MAT is often detrimental to patient care. Even if an insurance plan covers MAT, plans often impose burdensome prior authorization requirements or other arbitrary limits on treatment duration and/or dosage. There is no clear evidence that these requirements either improve the quality of patient care or save money; instead, they often result in unnecessary delays in receiving life-sustaining medications, and in psychiatrists using large amounts of what would otherwise be patient-focused time to complete the essential prescribing paperwork. **Some private insurers – such as Aetna, Anthem, Cigna, and UnitedHealth Group – have lifted prior authorizations for MAT and we encourage CMS to incentivize Medicare and Medicaid to do the same.** We also recommend the Committee consider policies that would require public and private plans to develop a publicly-accessible procedure through which patients can override drug plan step therapy protocols.

## **What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?**

### *Information Blocking*

One major logistical challenge to coordinating and improving data-sharing between Medicare, Medicaid, and PDMPs is that the current state of interoperability between these programs is more aspirational than actualized. Health IT software companies often engage in “information blocking” (otherwise known as “data hoarding”) to protect proprietary software specifications—mainly for strictly financial reasons. However, the 21st Century Cures Act contained provisions that, if adequately enforced, would help mitigate information blocking and help providers better coordinate care and address the opioid epidemic.

Section 4004(a) of 21st Century Cures provides that health IT vendors, exchanges, networks must avoid information blocking practices when they know, or should know, that “such practice is likely to interfere with, prevent, or materially discourage the access, exchange, or use of electronic health information.” **Given that proposed regulations implementing this provision are expected this April, we ask that the Committee carefully review these regulations to ensure they comply with the intent of the statute.**

### *Prescription Drug Monitoring Programs*

While we support the expansion of PDMPs and the availability of these programs to share information across state lines, it is important to keep in mind that PDMPs do not capture all prescription drugs that a patient is taking. If a provider doesn’t realize that such information is not included when they check the PDMP, he/she may inadvertently prescribe contra-indicated medication. **We recommend PDMPs include a notice to providers that clearly states the drugs excluded from the program (such as methadone),** so they can better understand the limitations of the data collected by the PDMP.

### *42 CFR Part 2 Reform*

The APA has always advocated for strong confidentiality protections of patient records. However, we are concerned that 42 CFR Part 2, Confidentiality of Privacy Records for Substance Use Disorders, is an ongoing barrier to meet the whole health needs of patients with substance use disorders and improve access to treatment for individuals impacted by the opioid crisis. As a means of beginning to overcome these barriers, **we recommend members of the Committee**

**support the bipartisan bill S.1850, the Protecting Jessica Grubb's Legacy Act.** The legislation would align Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of health care treatment, payment, and operations (TPO) and strengthen protections against the use of substance use disorder records in criminal proceedings.

**What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?**

#### *Integrated Care*

As states look to change their systems to control costs more effectively, many have begun to look to integrated health care as an approach for individuals with high health care costs and complex needs, including those who receive long-term services and supports. **CMS can look to state Medicaid programs, such as the "Hub and Spoke model" utilized in Vermont, to implement similar reforms in Medicare to better address the needs of those with opioid use disorder.** The Vermont model relies on a network of nine regional "hubs" that provide intensive MAT services and serve as a resource to the 75+ community-based "spoke" sites that provide outpatient maintenance MAT. According to a recent study by the Vermont Department of Health, this model led to a 96% decrease in opioid use while saving costs both in terms of a 90% decrease in arrests for opioid use and an 89% reduction in emergency room visits for opioid-related overdoses.

#### *Collaborative Care Model*

Likewise, Medicaid can also learn from effective programs currently implemented in Medicare and through the Innovation Center. Three decades of research and over 80 randomized control trials have identified the Collaborative Care Model as being cost effective and promoting early intervention and prevention by delivering behavioral health care in primary care settings. Medicare has supported the adoption of the Collaborative Care Model by establishing new payment codes as well as encouraging the implementation of the model through CPC+ program. Through CMS's Transforming Clinical Practice Initiative the APA is training of psychiatrists and primary care physicians in the model. Most recently Washington State has begun payment for this model through their Medicaid program and several states have expressed interest in using the codes in their Medicaid programs. **We urge CMS and the Committee to encourage adoption of these codes in state Medicaid plans and other initiatives funded by CMS.**

**What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?**

#### *Trauma-Informed Care*

Trauma takes a very high toll on individuals throughout the course of their lives. Research shows that traumatized children and adolescents display changes in levels of stress hormones, which are similar to those seen in combat veterans. These changes may affect the way traumatized children and adolescents respond to future stress in their lives and may lead to poorer health outcomes later in life. Evidence shows that individuals who experience trauma, particularly in childhood, have higher rates of chronic disease and behavioral issues.

There is much work to be done to increase access to appropriate mental health care for children and adolescents, particularly considering the traumatic effects of the ever-increasing epidemic of opioid addiction and deaths over the past decade. Unfortunately, children and adolescents have been ensnared in this epidemic both as active participants, and because of their relationships with parents and other family members with substance use disorders. **We urge the Committee to support the use of trauma-informed approaches in Medicaid and CHIP programs.**

#### *Telepsychiatry*

An ever-growing evidence base suggests that treatment via telepsychiatry demonstrates similar—and in some cases, superior—outcomes to in-person care, particularly amongst rural communities, certain cultural groups (such as Native American communities), and individuals with certain diagnoses (such as autism spectrum disorders). Telepsychiatry can also help to mitigate the stigma around seeking treatment for substance use disorders (in rural and urban locations alike) and also be used to boost access to psychiatric services in certain treatment settings, such as long-term, post-acute care settings (e.g., nursing homes) and emergency departments within federally qualified health centers (FQHCs).

We appreciate Congress easing restrictions for telemedicine to improve access to substance use disorder services with the inclusion of the CHRONIC Act in its most recent budget legislation. **We encourage the Committee to consider proposals that continue to expand telehealth coverage specifically for individuals requiring mental health and SUD services.**

*Medicaid Work Requirements*

We are concerned that any progress made on addressing the opioid crisis may be negated by the Administration's approval of 1115 waivers that would limit access to Medicaid with work requirements and enrollee cost-sharing. The evidence shows that these approaches create barriers to life-saving insurance coverage and do not improve patient outcomes. **We urge the Committee to oppose the Administration's efforts to limit access to Medicaid for those most in need.**

Thank you again for allowing us to offer our perspective on this crisis, and we look forward to working with the Committee on the development of lasting solutions. Our Federal Affairs team will follow up with Committee staff on the legislation referenced in this letter. If you have any questions, please contact Megan Marcinko at [mmarcinko@psych.org](mailto:mmarcinko@psych.org) / 202.559.3898 or Mike Troubh at [mtroubh@psych.org](mailto:mtroubh@psych.org) / 202.559.3571.

Sincerely,

A handwritten signature in black ink that reads "Saul Levin, MD, MPA". The signature is written in a cursive style and is placed on a white rectangular background.

Saul Levin, MD, MPA, FRCP-E  
CEO and Medical Director