AMERICAN PSYCHIATRIC ASSOCIATION

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March 15, 2018

The Honorable Kevin Brady
Chairman
House Ways and Means Committee
1102 Longworth HOB
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Ways and Means Committee
1102 Longworth HOB
Washington, DC 20515

The Honorable Peter Roskam
Chairman, Health Subcommittee
House Ways and Means Committee
1102 Longworth HOB
Washington, DC 20515

The Honorable Sander Levin
Ranking Member, Health Subcommittee
House Ways and Means Committee
1102 Longworth HOB
Washington, DC 20515

Dear Chairman Brady and Roskam and Ranking Members Neal and Levin:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing more than 37,800 psychiatric physicians, thank you for your recent request for stakeholder input regarding the opioid crisis.

As an organization representing front-line physicians who treat patients with substance use disorders, we are concerned about the impact the opioid crisis is having on patients, families, and communities. According to 2016 data from the National Survey on Drug Use and Health, approximately 19.9 million adults in the United States needed substance use disorder (SUD) treatment, yet only 2.1 million actually received the specialty care they needed. One of the primary reasons for this "treatment gap" is that many individuals lack health care coverage and therefore cannot afford treatment. To make productive gains in combating this public health crisis, the APA urges lawmakers to advance legislative solutions that will 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.

Again, we appreciate the Committee's attention to this important issue and are pleased to offer the following comments/recommendations:

Overprescribing/Data Tracking

Electronic Prior Authorization: The Committee seeks input on the value of standardizing the electronic prior authorization process and other improvements that could be made to improve coordination and prevent abuse.

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 losing potential patient-focused time to complete the required administrative tasks. As such, the standardization of electronic prior authorization would help to minimize the regulatory burden for physicians treating patients with OUD/SUD and improve the overall coordination of care. 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.

Prescription Drug Monitoring Programs (PDMPs): Currently, CMS does not have access to state PDMPs. The Committee seeks input regarding state PDMP data-sharing with CMS and other health care entities. Specifically, the Committee seeks information on potential barriers to implementation.

We support efforts by CMS to promote information sharing and data transparency efforts among PDMPs. One major logistical challenge to coordinating and improving data-sharing between 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.

In addition, 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.**

Finally, 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 for meeting the whole health needs of patients with substance use disorders and improving access to treatment for individuals impacted by the opioid crisis. **To overcome these barriers, we recommend members of the Committee support legislation to 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.**

Communication and Education

Prescriber Notification and Education: The Committee seeks input on the best methods for provider education on the adverse effects of prolonged opioid use, clinical guidelines for alternative pain treatments, and clinical guidelines for opioid prescribing. The Committee also seeks input on effective ways to notify providers who prescribe such medicines in excess of their peers.

As lawmakers and various stakeholders continue to assess various avenues to mitigate the current crisis, it is critically important to highlight the necessity of striking a balance in measuring the risks of opioids, while also maintaining access for patients with acute pain who benefit from these drugs. The APA strongly supports increasing education and training opportunities for providers, and we recommend working with specialty medical societies to develop specific guidelines on appropriate prescribing. We also recommend encouraging medical schools to continue to enhance their curricula on opioid prescribing and the risk of developing a substance use disorder.

Treatment

Opioid Treatment Programs (OTPs) and Medication Assisted Treatment (MAT): The Committee seeks input from providers around best practices for identification and referral to OTPs, as well as how an OTP benefit could be integrated into the Medicare fee-for-services program – whether through bundled payments or otherwise. The Committee seeks input on the types of providers that are involved in delivery of MAT, best practices to promote coordinated and

managed care, and current reimbursement challenges providers face through Medicaid and commercial plans.

The APA supports efforts to minimize barriers to MAT by easing prior authorization requirements and making available (via coverage and reimbursement) all FDA-approved medications for treating substance use disorders, including long-acting buprenorphine formulations that reduce the risk of relapse and improve adherence. The APA also supports CMS efforts that any proposed benefit plan that would implicitly or explicitly discourage enrollment by beneficiaries in need of these therapies will not be approved. It is imperative to ensure that Medicare beneficiaries have appropriate access to MAT, and we continue to expect Part D sponsors to include products in preferred formulary tiers, and to avoid placing generic drugs indicated for MAT in brand tiers. As CMS has noted via guidance documents, the agency will closely scrutinize formulary and benefit submissions with respect to formulary inclusion, utilization management criteria, and cost-sharing for Part D drugs indicated for MAT. Given that Medicare has no comprehensive SUD treatment benefit, including reimbursement for services delivered or drugs dispensed by an OTP, **we urge lawmakers to support and encourage 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**

In addition, 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.**

Finally, as states continue to assess and augment their systems as a means to control costs more effectively, many have begun to broaden their use of 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. **We encourage CMS to examine state Medicaid programs, such as Vermont's "Hub and Spoke" model as potential templates for implementing similar reforms in**

Medicare to better address the needs of those with OUD. 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 percent decrease in opioid use, while saving costs both in terms of a 90 percent decrease in arrests for opioid use and an 89 percent reduction in emergency room visits for opioid-related overdoses.

Reimbursement: The Committee seeks input from providers around resource use and reimbursement issues that should be considered for Medicare population when expanding treatment options.

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, while patients experience disparities in coverage for these same services. According to the 2017 Milliman report entitled, "Impact of Mental Health Parity and Addiction Equity Act," 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.**

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 / 202.559.3898 or Mike Troubh at mtroubh@psych.org / 202.559.3571.

Sincerely,

Saul Levin, MD, MPA

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