NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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Rep. Kevin Brady, Chairman
Rep. Richard Neal, Ranking Member
Rep. Peter Roskam, Health Subcommittee Chairman
Rep. Sander Levin, Health Subcommittee Ranking Member
U.S. House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515-6348

15 March 2018

Dear Reps. Brady, Neal, Roskam, and Levin:

The National Association of Psychiatric Health Systems (NAPHS)—on behalf of our more than 1,000 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care—thanks you for this opportunity to provide policy options for addressing the opioid crisis.

NAPHS represents the entire behavioral healthcare continuum. Behavioral health encompasses both mental health and substance use disorders, and the care continuum includes inpatient care, partial hospitalization services, residential treatment and outpatient services. Our diverse membership positions us well to help solve our nation's deadly and pervasive opioid problem.

Background
Most substance use disorders (SUDs) go untreated. In 2016, 20.1 million Americans had an SUD and needed treatment. Within that group, only 11 percent of people received services, leaving 89 percent of these individuals without treatment of any kind.[1] This is referred to as the "treatment gap." Meanwhile, more than 63,000 people—roughly 174 people every day—died from a drug overdose in 2016, reflecting a 21-percent increase from 2015.[2] Two-thirds of these deaths involved an opioid and were driven largely by heroin overdoses, which have increased 533 percent since 2002. These trends show no signs of stopping. In 45 states the opioid overdoses went up 30 percent from July 2016 through September 2017.[3] Despite these statistics, only 19 percent of individuals with an opioid use disorder (OUD) received OUD treatment,[4] and only 26 percent of individuals with a heroin use disorder received medication assisted treatment (MAT).

[1] SAMHSA, Center for Behavioral Health Statistics and Quality. *2016 National Survey on Drug Use and Health, Detailed Tables, Table 5.50A* (September 2017), *2016 National Survey on Drug Use and Health, Detailed Tables, Table 5.50A*
[2] Hedegaard H, Warner M, Miniño AM. *Drug overdose deaths in the United States, 1999–2016.* NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017.
[3] Centers for Disease Control and Prevention. *Vital Signs Report: Opioid Overdoses Treated in Emergency Departments* March 7, 2018
[4] WuL.-T. Wu et al. / *Treatment utilization among persons with opioid use disorder in the United States.* Drug and Alcohol Dependence 169 (2016) 117–127

Reflecting this trend, opioid-related hospitalizations increased by 150 percent between 1993 and 2012.[5] Between 2005 and 2014, the national rate of opioid-related inpatient stays increased 64.1 percent and the national rate of opioid-related emergency department visits nearly doubled with an increase of 99.4 percent.[6] Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids.

The good news is recovery from SUDs is possible with effective treatment. However, the rates of recovery are significantly low because most patients do not access the treatment system. Effective treatment programs include a range of services that address individual patient needs, but too often patients do not receive evidence-based care. And when they do receive care, they rarely receive the right amount of care. Moreover, the range of treatment is not always coordinated and often falls short of managing symptom recurrence (known as "relapse") and sustaining long-term recovery.

These data show clearly that in the fight against opioids we need to:

- modify the recently announced $6 billion in federal funding for the opioid crisis to encourage states to pilot financing models for addiction care that are independent of traditional grants;
- expand access to all FDA-approved addiction medicines for Medicare beneficiaries; and
- provide states relief from the antiquated Institutions for Mental Diseases (IMD) exclusion.

Medicare 190 Lifetime Limit

Medicare beneficiaries are limited to only 190 days of inpatient care in a psychiatric hospital in their lifetimes. No other lifetime limits exist in Medicare for any other type of inpatient care. Eliminating the 190-day lifetime limit will equalize Medicare behavioral health coverage with private health insurance coverage, expand beneficiary choice, increase access for the most seriously ill, improve continuity of care, and create a more cost-effective Medicare program. NAPHS has endorsed Rep. Paul Tonko's (D-N.Y.) *Medicare Mental Health Inpatient Equity Act* (H.R.2509) that would repeal the 190-day lifetime limit, and the committee should pass it.

Grant Modification to Support Treatment

Block grant funds and other supplementary grants are critical to the public-sector safety net for individuals with addictions. However, this grant financing is limited and may not be the most effective way to engage the private sector in a way that could change the trajectory of opioid crisis. In 2016, funding from the *21st Century Cures Act* (*Cures*) began to flow to states through the Substance Abuse and Mental Health Services Administration's (SAMHSA) block grant. But reports indicate that *Cures* funding is not translating into treatment for patients quickly enough. Private-sector health systems have untapped capacity that remains unused. These systems are poised to provide services immediately, which would reduce the treatment gap. We need a disruptive approach that leverages federal funds and private-sector resources to fight the opioid crisis.

Congress should create an Opioid and Substance Use Treatment and Recovery Fund, which would allow state insurance commissioners to close the treatment gap through a state-based program that provides payment for a patient's SUD treatment when existing public and private payers do not—or cannot— cover that treatment. This flexible financing model would direct federal funding toward effective evidence-based addiction treatment quickly. To be clear: this new financing mechanism is not intended to replace block-grant funding, nor is it meant to relieve existing insurers of their obligations under the *Mental Health Parity and Addiction Equity Act*. Rather, this would establish an additional method for states to receive and disburse funding quickly to for-profit and not-for-profit addiction treatment providers, who, in turn, are well-positioned to address the gaps in their existing SUD treatment programs.

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[5] Owens PL, Barrett ML, Weiss AJ, et al: *Hospital Inpatient Utilization Related to Opioid Overuse Among Adults, 1993–2012* Statistical Brief #177. Agency for Healthcare Research and Quality, Rockville, Md. 2014.

[6] Weiss AJ, Elixhauser A, Barrett ML, Steiner CA, Bailey MK, O'Malley L. *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009–2014*. HCUP Statistical Brief #219. December 2016. Agency for Healthcare Research and Quality, Rockville, MD.

Under this approach, the Centers for Medicare & Medicaid Services (CMS) would distribute funding to state insurance commissioners nationwide based on state-designed plans for treatment or recovery support services from licensed, not-for-profit and for-profit providers who treat individuals with opioid and substance use disorders, or co-occurring substance use disorder and mental health disorders. The funds should cover services for direct inpatient, partial hospitalization, and intensive outpatient care, as well as outpatient counseling, medications, medication and services provided in opioid treatment programs, office-based opioid agonist treatment, other FDA-approved addiction medicines, recovery-support services, expert addiction consultation services, collaborative care and telehealth.

This supplementary approach is a patient-focused financing model in which the money follows the patient and is tailored to the patient's clinical needs, and choice of treatment, setting and provider.

Medicare Beneficiary Access to Addiction Treatment
According to the *Journal of the American Medical Association*, "the population that uses Medicare…has among the highest and most rapidly growing prevalence of opioid use disorder, with more than 6 of every 1000 patients diagnosed and with hospitalizations increasing 10 percent per year." One cause of this problem is that while Medicare parts A and D cover methadone, part B does not cover methadone as an outpatient treatment for opioid addiction. Committee members should pass legislation to allow Medicare beneficiaries to access critical methadone treatment under Medicare part B in outpatient settings.

Medicaid Institutions for Mental Diseases (IMD) exclusion
Since 1965, the IMD exclusion has prohibited federal payments to states for services to adult Medicaid beneficiaries between the ages of 21 and 64 who are treated in facilities that have more than 16 beds, and that provide inpatient or residential behavioral health (SUDs and mental illness) treatment. While NAPHS supports a full repeal of the IMD, which two federal commissions—one non-partisan and the other bipartisan—recommended in the last year, we understand it may be necessary to take interim steps before that happens. One such step is to modify the Medicaid managed care rule that the Centers for Medicare & Medicaid Services (CMS) made final in 2016.

Changing the per-stay cap to 25 days would have a significant, positive effect on psychiatric hospital care and SUD treatment. First, although most psychiatric hospital stays are fewer than 15 days, there are a significant number of cases in which it is "medically necessary" for patients to stay more than 15 days to stabilize their mental health conditions. Next, residential stays for SUD treatment tend to be longer than hospital stays for mental health treatment. As a result, even though most SUD stays exceed the limit, many of these cases could be accommodated with an average facility length-of-stay cap of 25 days.

42 CFR Part 2
Federal regulations established in the 1970s known as 42 CFR Part 2, or "Part 2," currently govern the confidentiality of medical information about individuals who have applied for or received substance abuse diagnosis or treatment in a program that primarily provides SUD treatment. Part 2 is more stringent (i.e., privacy-protective) than the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA). And when Part 2 is applied to the current digital era, the regulations are an impediment to healthcare integration, which can endanger patients. Committee members should reform Part 2 to improve information-sharing while protecting individuals from using medical records in criminal, civil, and administrative prosecution and discrimination.

Helping Americans Seek Treatment Act (H.R. 4769)
SAMHSA has a national substance use disorder treatment resource called the National Helpline, which is a free, confidential, treatment referral and information service available 24 hours a day, seven days a week for individuals and families facing mental and/or substance use disorders. However, not many people know about the National Helpline, and it is not being used as widely as it could be. Committee members should support Rep. Tom Marino's (R-Pa.) *Helping Americans Seek Treatment Act*, which would establish a national campaign to increase awareness of the National Helpline.

Other Policies

The Committee should also consider ways to remove reimbursement and policy barriers to SUD treatment, increase parity enforcement authority at the U.S. Labor Department, revise policies to allow SUD treatment via telemedicine, and expand the use of MAT at all levels of care for adolescents, adults, and expectant mothers.

Thank you for considering our comments. We would be happy to provide detailed information on any of the recommendations included in this letter.

And we look forward to working with the Committee and the entire Congress to ensure that all Americans have access to high-quality, life-saving behavioral healthcare services.

Sincerely,

Mark Covall
President/CEO