**Documents for the Record – 06/21/23**

**Majority:**

- May 18, 2023 letter from the National Association of Attorneys General, submitted by Rep. Bilirakis
- June 20, 2023 letter from AVMA, submitted by Rep. Bilirakis
- June 21, 2023 letter from the National Association for Children's Behavioral Health, submitted by Rep. Bilirakis
- June 21, 2023 Braeburn testimony of Neely Frye
- June 20, 2023 letter from the Treatment Advocacy Center, submitted by Rep. Burgess
- June 20, 2023 letter from Bipartisan Policy Center Action, submitted by Rep. Burgess
- June 15, 2023 letter from the National Association of State Mental Health Program Directors, submitted by Rep. Burgess
- June 21, 2023 letter from the Schizophrenia & Psychosis Action Alliance, submitted by Rep. Burgess
- June 20, 2023 letter from Pyramid Healthcare, submitted by Rep. Burgess

**Minority:**

- May 31, 2023 letter from a mental health coalition on H.R. 3074
- April 26, 2023 letter from law enforcement organizations on MIEP
- June 21, 2023 letter from the American Academy of Family Physicians
- June 20, 2023 letter from AFSCME
- June 20, 2023 letter from BPC Action
- June 8, 2023 letter from coalition on Due Process Continuity of Care Act
- June 13, 2023 letter from members of Congress on H.R. 2074 and H.R. 2400
- June 20, 2023 letter from coalition on H.R. 824
- June 20, 2023 letter from NAMI
- June 21, 2023 letter from coalition of 23 orgs on H.R. 824
- June 20, 2023 letter from Anoka County Board of Commissioners

NATIONAL ASSOCIATION OF ATTORNEYS GENERAL

PRESIDENT
**Dave Yost**
Ohio
Attorney General

PRESIDENT-ELECT
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May 18, 2023

The Honorable Kevin McCarthy
Speaker
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2468 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Chuck Schumer
Majority Leader
U.S. Senate
322 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
2433 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
317 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Cathy McMorris Rodgers
Chair, Energy & Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Dick Durbin
Chair, Judiciary Committee
U.S. Senate
711 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Frank Pallone
Ranking Member, Energy & Commerce Committee
U.S. House of Representatives
2107 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Lindsey Graham
Ranking Member, Judiciary Committee
U.S. Senate
211 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Jim Jordan
Chair, Judiciary Committee
U.S. House of Representatives
2138 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Jerrold Nadler
Ranking Member, Judiciary Committee
U.S. House of Representatives
2132 Rayburn House Office Building
Washington, D.C. 20515

RE: Support Passage of S. 993/ H.R. 1839- the Combating Illicit Xylazine Act

Dear Speaker, Majority Leader, Minority Leaders, Chairs, and Ranking Members:

We, the undersigned Attorneys General, write you to request that you pass S. 993/ H.R. 1839, the Combating Illicit Xylazine Act, without delay. This bipartisan legislation seeks to curb the proliferation of illicit xylazine by classifying its use as a controlled substance to stop the death that this drug is causing across the United States.

Xylazine is a drug that the Administrator for the Drug Enforcement Administration (the "DEA") recently warned was "making the deadliest drug threat our country has ever

faced, fentanyl, even deadlier."[1] Known on the street as "tranq"[2] or "zombie drug," the DEA believes that xylazine is so dangerous that it recently issued a "Public Safety Alert." For context, the only other "Public Safety Alerts" issued by the DEA in the last three years concerned fentanyl and its rise in use and death. The DEA did so because last year, "approximately 23% of fentanyl powder and 7% of fentanyl pills seized by the DEA contained xylazine."[3] As stated in the alert, xylazine alone or mixed with other drugs, like fentanyl, is dangerous because it is a sedative known to depress breathing, blood pressure, heart rate, and body temperature, as well as cause unconsciousness, necrosis, and death.

Indeed, according to the Centers for Disease Control and Prevention ("CDC"), "because xylazine is not an opioid, it does not respond to opioid reversal agents such as naloxone; therefore, if illicit opioid products containing xylazine are used, naloxone might be less effective in fully reversing an overdose."[4] That report, which looked at 2019 data from the State Unintentional Drug Overdose Reporting System in 38 states and the District of Columbia, found Xylazine in 2% of overdose deaths.[5] However, according to the National Institute on Drug Abuse ("NIDA"), the number of fatalities involving xylazine is increasing exponentially.[6] One study cited by NIDA found xylazine increasingly present, finding it in 25.8% of the overdose deaths in the City of Philadelphia, 19.3% of the overdose deaths in the State of Maryland, and 10.2% of overdose deaths in the State of Connecticut.[7] According to another report by the American Psychiatric Association, xylazine's prevalence in overdose deaths rose from .36% in 2015 to 6.7% in 2020, almost a nineteen-fold increase.[8]

Xylazine is a non-opioid veterinary tranquilizer for large animals, like horses and deer.[9] It is not approved for human use, and there is no accepted medical use in humans, nor is it currently a controlled substance under the federal Controlled Substances Act (CSA), 21 U.S.C. §813. Some states, such as Florida, have scheduled xylazine as a Schedule 1 controlled substance.[10] Research has shown xylazine is often added to illicit opioids, including most frequently fentanyl, and users report using xylazine-containing Fentanyl to lengthen its euphoric effects.[11] The White House, pursuant to the SUPPORT Act of 2018, recently declared fentanyl-adulterated or fentanyl-associated xylazine (FAAX) an "emerging threat."[12]

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[1] *DEA Reports Widespread Threat of Fentanyl Mixed with Xylazine*, DEA, (last visited Apr. 27, 2023) [hereinafter DEA Public Safety Alert], www.dea.gov/alert/dea-reports-widespread-threat-fentanyl-mixed-xylazine.

[2] Jewell Johnson et al., Increasing Presence of Xylazine in Heroin and/or Fentanyl Deaths, Phildelphia, Pennsylvania, 2010-2019, 27 INJ. PREVENTION 395, 395–98 (2021).

[3] DEA Public Safety Alert, *supra* note 1.

[4] Mbabazi Kariisa et al., Xylazine Detection and Invovlement in Drug Overdose Deaths – United States, 2019,

[5] Id.

[6] *Xylazine*, Nat'l Inst. on Drug Abuse, Nat'l Insts. of Health (last visited Apr. 27, 2023), https://nida.nih.gov/research-topics/xylazine.

[7] Joseph Friedman et al., Xzylazine Spreads Across the US: A Growing Component of the Increasingly Synthetic and Polysubstance Overdose Crisis, DRUG & ALCOHOL DEPENDENCE, Apr. 2022.

[8] Terri D'Arrigo, *Xylazine Increasingly Found in Overdose Deaths*, PSYCHIATRIC NEWS (June 27, 2022), https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.07.6.5.

[9] Press Release, FDA, FDA Takes Action to Restrict Unlawful import of Xylazine (Feb. 28, 2023) [hereinafter FDA Press Release], https://www.fda.gov/news-events/press-announcements/fda-takes-action-restrict-unlawful-import-xylazine.

[10] Fla. Stat. § 893.03.

[11] Shobha Thangada et al., Xylazine, a Veterinary Tranquilizer, Identified as an Emerging Novel Substance in Drug Overdose Deaths — Connecticut, 2019–2020, 70 MORBIDITY & MORTALITY WEEKLY REP. 1303, 1303–04 (2021).

[12] Press Release, White House, Biden-Harris Administration Designates Fentanyl Combined with Xylazine as an Emerging Threat to the United States (Apr. 12, 2023), https://www.whitehouse.gov/ondcp/briefing-room/2023/04/12/biden-harris-administration-designates-fentanyl-combined-with-xylazine-as-an-emerging-threat-to-the-united-states/.

Though, as noted by the DEA, there is limited scientific research on the effects of xylazine on the human body, there are anecdotal reports that xylazine users experience effects like opioids.[13] There is also some evidence that some people seek out xylazine on its own or combined with heroin because of its effects.[14] The DEA has also noted that xylazine users may develop "a physical dependence to xylazine itself, with some users reporting the withdrawal symptoms from xylazine as, or more, severe than from heroin or methadone; symptoms include sharp chest pains and seizures."[15] The full extent and nature of psychological or physical dependence that xylazine causes appear to be unknown because of a lack of research and how commonly it is used with other controlled substances.

The Food & Drug Administration (the "FDA") approved xylazine for veterinary use, and thus it is currently readily available for purchase over the Internet sites, often with no association to the veterinary profession nor requirements to prove legitimate need. In a recent intelligence report, the DEA noted, "[a] kilogram of xylazine powder can be purchased online from Chinese suppliers with common prices ranging from $6-$20 U.S. dollars per kilogram."[16] Given the low price, the DEA has warned that xylazine's use as an adulterant for other illicit drugs is growing to allow traffickers to increase their profits.[17] The increase in deaths caused the FDA to attempt to restrict the unlawful importation of xylazine and restrict importation and distribution to legitimate veterinary use in the United States.[18] But, federal authorities are still encountering a rise in xylazine in connection with fentanyl being trafficked from Mexico by the Sinaloa and Jalisco Cartels using chemicals sourced from China.[19]

There is limited information regarding the prevalence of xylazine as many States have not tested for its presence in seizures or overdose deaths until recently. The DEA reports that its prevalence is increasing, and 48 out of 50 States have encountered xylazine.[20] However, the national statistics on the presence of xylazine in overdose deaths are "widely underestimated" because of limited testing and the variance in testing procedures.[21] Despite the limited data, the DEA reported significant increases in xylazine-positive deaths.[22]

| Region | 2020 | 2021 | Percent Increase |
|---|---|---|---|
| Northeast | 631 | 1281 | 103% |
| South | 116 | 1423 | 1127% |
| Midwest | 57 | 351 | 516% |
| West | 4 | 34 | 750% |

Many of our States have scheduled xylazine, though some minor disagreement exists over which Schedule to place xylazine. Nevertheless, we agree that Congress must act quickly to classify the illicit use of xylazine under Schedule III of the CSA. The Combating Illicit Xylazine Act provides critical tools that will enable the DEA to track its manufacturing, prevent diversion, and mandate analysis and reporting on the illicit use of xylazine.

The undersigned Attorneys General have a longstanding commitment to helping our communities recover from the opioid epidemic. For years, we have stood on the front line in the fight to end the opioid epidemic. We

[13] DEA, U.S. DEP'T OF JUSTICE, THE GROWING THREAT OF XZLAZINE AND ITS MIXTURE WITH ILLICIT DRUGS 4 (2022), https://www.dea.gov/sites/default/files/2022-12/The%20Growing%20Threat%20of%20Xylazine%20and%20its%20Mixture%20with%20Illicit%20Drugs.pdf.
[14] *Id.* at 1.
[15] *Id.* at 2.
[16] *Id.* at 1.
[17] Id.
[18] FDA Press Release, *supra* note 9.
[19] DEA Public Safety Alert, *supra* note 1.
[20] *Id.*
[21] Id.
[22] Id.

continue to seek accountability from opioid manufacturers, distributors, dispensers, and others in the opioid supply chain for their role in unleashing this epidemic. In addition to the critical injunctive relief imposed upon these companies, billions of dollars are beginning to flow to communities across the country to abate the epidemic.

Xylazine is a growing danger to communities across our nation. With a record number of overdose deaths, we must confront this new threat. Therefore, as Attorneys General of our respective States, we urge you to pass the Combating Illicit Xylazine Act without delay.

The four co-sponsors of this letter – Connecticut, Florida, New York, and Tennessee – are joined by the undersigned attorneys general across the U.S. states and its territories.

Sincerely,

William Tong
Connecticut Attorney General

Ashley Moody
Florida Attorney General

Letitia James
New York Attorney General

Jonathan Skrmetti
Tennessee Attorney General

Steve Marshall
Alabama Attorney General

Treg R. Taylor
Alaska Attorney General

Kris Mayes
Arizona Attorney General

Tim Griffin
Arkansas Attorney General

Rob Bonta
California Attorney General

Phil Weiser
Colorado Attorney General

Kathleen Jennings
Delaware Attorney General

Brian Schwalb
District of Columbia Attorney General

Christopher M. Carr
Georgia Attorney General

Anne E. Lopez
Hawaii Attorney General

Kwame Raoul
Illinois Attorney General

Todd Rokita
Indiana Attorney General

Daniel Cameron
Kentucky Attorney General

Jeff Landry
Louisiana Attorney General

Anthony G. Brown
Maryland Attorney General

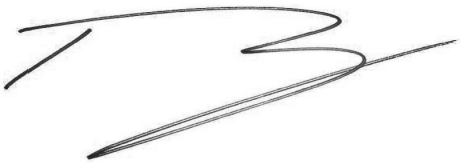
Dana Nessel
Michigan Attorney General

Keith Ellison
Minnesota Attorney General

Andrew Bailey
Missouri Attorney General

Aaron D. Ford
Nevada Attorney General

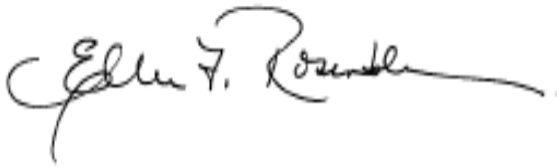
John M. Formella
New Hampshire Attorney General



Raúl Torrez
New Mexico Attorney General

Josh Stein
North Carolina Attorney General

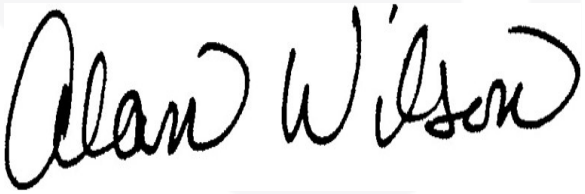
Gentner Drummond
Oklahoma Attorney General



Ellen F. Rosenblum
Oregon Attorney General

Michelle Henry
Pennsylvania Attorney General

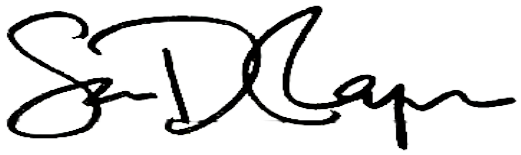
Peter F. Neronha
Rhode Island Attorney General



Alan Wilson
South Carolina Attorney General

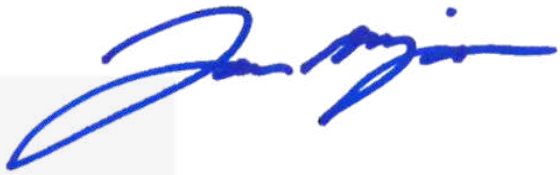
Marty Jackley
South Dakota Attorney General

Ken Paxton
Texas Attorney General

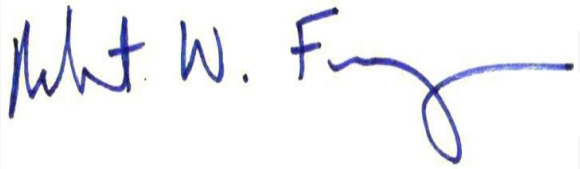


Sean D. Reyes
Utah Attorney General

Charity Clark
Vermont Attorney General



Jason S. Miyares
Virginia Attorney General



Robert W. Ferguson
Washington Attorney General

Patrick Morrisey
West Virginia Attorney General

Joshua L. Kaul
Wisconsin Attorney General

June 20, 2023

The Honorable Dick Durbin
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

The Honorable Lindsey Graham
Ranking Member
Committee on the Judiciary
United States Senate
Washington, DC 20510

The Honorable Cathy McMorris Rodgers
Chairwoman
Energy & Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy & Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Jim Jordan
Chairman
Judiciary Committee
United States House of Representatives
Washington, DC 20515

The Honorable Jerrold Nadler
Ranking Member
Judiciary Committee
United States House of Representatives
Washington, DC 20515

Dear Chairs Durbin, McMorris Rodgers, and Jordan and Ranking Members Graham, Pallone, and Nadler:

On behalf of the American Veterinary Medical Association's (AVMA) 101,000 veterinarian members, all 50 state and two territory veterinary medical associations, and 11 supporting stakeholder organizations, we urge you to swiftly pass the **Combating Illicit Xylazine Act (H.R. 1839/S. 993)** – a bipartisan bill that would equip the U.S. Drug Enforcement Agency with the necessary tools to address the emerging threat of illicit xylazine while preserving veterinary access to this essential animal sedative that is used throughout veterinary medicine.

The veterinary community is not taking the drug epidemic and the role illicit xylazine plays lightly. Illicit xylazine has now been found across the country mixed with fentanyl and other narcotics. This potent drug combination poses grave health and safety risks to human users. In veterinary medicine, xylazine is an important prescription sedative used to facilitate the safe handling and treatment of many species and is particularly important for use in cattle, horses, wildlife, and research species. In cattle, this is an essential drug for safe handling as there is no practical alternative for sedation.

We support this legislation because it strikes the right balance of helping protect our communities from illicit xylazine while maintaining veterinarians' access and ability to legitimately use this critical animal sedative under its current prescription status, regulated by the Food and Drug Administration and state law. It is our understanding that there is not significant

diversion of xylazine from veterinary channels; however, under the proposed legislation, any diversion would be subject to penalties under the federal Controlled Substances Act.

Inaction from Congress on this legislation will disrupt the legitimate veterinary supply chain of legal xylazine, jeopardizing human safety and animal welfare. Our organizations are deeply concerned about the emerging public health threat of illicit xylazine and the negative impact it is having throughout the country. We echo the request from 39 Attorneys General urging congressional leadership to pass the bipartisan, bicameral **Combating Illicit Xylazine Act** without delay**.**

Please contact Dr. Lindsey Hornickel with the AVMA at lhornickel@avma.org should you have any questions.

Thank you for your timely consideration of this request.

Sincerely,

Lori Teller DVM, DABVP (canine/feline), CVJ
President, American Veterinary Medical Association

**State and Territory Veterinary Medical Associations**
Alabama Veterinary Medical Association
Alaska State Veterinary Medical Association
Arizona Veterinary Medical Association
Arkansas Veterinary Medical Association
California Veterinary Medical Association
Colorado Veterinary Medical Association
Connecticut Veterinary Medical Association
Delaware Veterinary Medical Association
District of Columbia Veterinary Medical Association
Florida Veterinary Medical Association
Georgia Veterinary Medical Association
Hawaii Veterinary Medical Association
Idaho Veterinary Medical Association
Illinois State Veterinary Medical Association
Indiana Veterinary Medical Association
Iowa Veterinary Medical Association
Kansas Veterinary Medical Association
Kentucky Veterinary Medical Association
Louisiana Veterinary Medical Association

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Nevada Veterinary Medical Association
New Hampshire Veterinary Medical Association
New Jersey Veterinary Medical Association
New Mexico Veterinary Medical Association
New York State Veterinary Medical Society
North Carolina Veterinary Medical Association
North Dakota Veterinary Medical Association
Ohio Veterinary Medical Association
Oklahoma Veterinary Medical Association
Oregon Veterinary Medical Association
Pennsylvania Veterinary Medical Association
Puerto Rico Veterinary Medical Association
Rhode Island Veterinary Medical Association
South Carolina Association of Veterinarians
South Dakota Veterinary Medical Association
Tennessee Veterinary Medical Association
Texas Veterinary Medical Association
Utah Veterinary Medical Association
Vermont Veterinary Medical Association
Virginia Veterinary Medical Association
Washington State Veterinary Medical Association
West Virginia Veterinary Medical Association
Wisconsin Veterinary Medical Association
Wyoming Veterinary Medical Association

**Stakeholder Groups**
American Association of Bovine Practitioners
American Association of Equine Practitioners
American Association of Small Ruminant Practitioners
American Academy of Veterinary Pharmacology and Therapeutics
American College of Veterinary Clinical Pharmacology
Animal Health Institute
American Horse Council
National Association for Biomedical Research

National Animal Control and Care Association
National Milk Producers Federation
North American Meat Institute

**Cc:**
The Honorable Cory Booker
The Honorable Tom Cotton
The Honorable Brett Guthrie
The Honorable Anna Eshoo
The Honorable Andy Biggs
The Honorable Shelia Jackson Lee

NACBH
National Association *for* Children's Behavioral Health

June 21, 2023

The Honorable Gus Bilirakis
2306 Rayburn House Office Building
Washington, DC 20515

The Honorable Kathy Castor
2052 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Bilirakis and Castor:

The National Association for Children's Behavioral Health (NACBH), a nationwide nonprofit coalition of licensed and accredited children's behavioral health providers, is writing to express our strong support for the bipartisan Ensuring Medicaid Continuity for Children in Foster Care Act (H.R.4056) led by your offices. NACBH is committed to advancing the field of children's behavioral health and leveraging our expertise to shape the legislation that affects the children we serve every day. Our nationwide membership includes nonprofit behavioral health treatment facilities from Alaska to Mississippi providing crisis intervention, home-based and community wraparound services, as well as intermediate levels of care such as intensive outpatient, partial hospitalization, and residential treatment programs.

We thank the House Energy and Commerce Committee for their commitment to reauthorizing the Substance Use Disorder Prevention that Promotes Recovery and Treatment (SUPPORT) Act and ensuring that young patients have access to the behavioral health care they need. Many of our members serve youth in the child welfare system as well as their birth and foster families, meaning we necessarily braid funding across Medicaid and Title IV-E. However, due to the Institutions for Mental Disease (IMD) exclusion, our Qualified Residential Treatment Program (QRTP) designated facilities are currently ineligible for a federal Medicaid match for any of the health care services delivered to patient residents. This exclusion magnifies mental and physical health equity issues in the communities we serve and contributes to lack of treatment availability for necessary acute care in rural, urban, and suburban areas.

The nation is facing a pediatric mental health crisis; the past 10 years have seen a 50% increase in negative mental health outcomes for high-school aged youth[1] and a 62% increase in suicide death rates among youth aged 12-17. Simultaneously, child welfare system-involved youth are at a higher risk for trauma and mental and behavioral health needs, heightening Medicaid coverage issues for the patients with the greatest need. Up to 80% of children in foster care have significant mental and behavioral health needs[2] and youth with child welfare system experience are nearly four times more likely to have considered or attempted suicide compared to youth who had never been in foster care.[3]

The Ensuring Medicaid Continuity for Children in Foster Care Act would finally exempt QRTPs from the IMD exclusion, ensuring that physical and mental health coverage is available to foster care children in necessary residential treatment environments. By making this simple change – cross-referencing title IV-E and Medicaid statute – we can clarify federal directives to State Medicaid Agencies and take the guesswork out of treating patients. With our strong support, we urge you to swiftly advance this legislation out of committee and to the House floor to ensure every child and family has access to the level of care clinically indicated for them.

---

[1] Centers for Disease Control and Prevention. (2023). Youth Risk Behavior Survey Data Summary & Trends: 2011-2021.
[2] Dore, M. (2005). Child and adolescent mental health. In G. Mallon and P. Hess (eds.), Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies and Programs. (148-172) New York: Columbia University Press.
[3] Pilowsky DJ, Wu LT. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. J Adolesc Health. 38(4):351-8. doi: 10.1016/j.jadohealth.2005.06.014. PMID: 16549295; PMCID: PMC1472845.

Sincerely,

NACBH Board of Directors, Policy Committee

*Barry Robinson Center*

*Brightpoint (formerly Children's Home & Aid)*

*Canopy Children's Solutions*

*Crossroad Child & Family Services*

*Gibault Children's Services*

*Klingberg Family Centers*

*Northwood Children's Services*

**Testimony of Neely Frye**
**Director of Government Affairs**
**House Energy and Commerce Committee; Health Subcommittee**
**"Support for Reauthorization of the SUPPORT Act"**
**June 21, 2023**

Introduction

On behalf of Braeburn Inc., I applaud the House Energy and Commerce Committee's dedication and thoughtful approach to enacting policy that addresses the evolving opioid epidemic facing our nation.

Last year, the Committee's sharp focus on improving the lives of those in substance use treatment and recovery along with a steadfast commitment to shepherding the Restoring Hope for Mental Health and Well-Being Act to overwhelming passage in the House, provided the momentum needed to cement the Act's provisions in the 2023 Omnibus Appropriations bill which became law in December 2022. Among other things, this action served to overhaul the 14-Day Rule and tear down a barrier to health care practitioners using innovative therapies to support people in substance use treatment. Braeburn thanks the Committee for dedicating time and intellectual bandwidth to understanding how a shot clock of just 14 days impedes a health care practitioner from utilizing innovative injectable buprenorphine products in patient care. Practitioners were unable to obtain the product via specialty pharmacy and then schedule a follow up appointment and administer the treatment to a patient within a narrow 14-day time period. The Committee's work to expand the window to 60 days gives providers and patients flexibility to tailor treatment and achieve desired outcomes.

Braeburn is a Pennsylvania-based healthcare company whose mission is to combat the opioid crisis by developing innovative treatments for opioid use disorder (OUD). On May 23, 2023, Braeburn's very first product, BRIXADI® (buprenorphine) extended-release injection for subcutaneous use, was approved by FDA. BRIXADI is approved for the treatment of moderate to severe OUD and is the first and only injectable buprenorphine product with both weekly and monthly doses. BRIXADI will be available only through a restricted program called the BRIXADI REMS because of the risk of serious harm or death that could result from intravenous self-administration. Because BRIXADI should never be dispensed to a patient, the product will only be available to and administered by a healthcare provider. The weekly and monthly formulation affords health care practitioners much-needed flexibility to meet an individual where they are and personalize treatment and recovery support. BRIXADI is available in seven different dosage levels to give providers and patients more options to personalize OUD treatment – providing the appropriate dose for appropriate patients.

Long-acting injectable buprenorphine products, like BRIXADI, have been welcomed by officials at SAMHSA and NIH because weekly and monthly formulations give doctors and patients more options to personalize OUD treatment. Medications for opioid use disorder (MOUD) that meet the patient's unique needs may foster treatment adherence and sustained recovery. As BRIXADI and other innovative therapies enter the market, access to them can help shape the direction our nation moves in addressing addiction and overdoses, along with the impact these have on patient lives.

The SUPPORT Act set in motion bold action to prevent, reduce, and overcome the grip of opioid use disorder by transforming access to treatment, reevaluating prescribing patterns, shattering long-held stigmas, spurring development of new therapies, and supporting patients in more holistic ways.

Braeburn's core purpose has always been and will remain to transform the management of OUD to help people begin and sustain their recovery. Braeburn is dedicated to delivering solutions for people living with the serious, often fatal consequences of opioid use disorder. We are committed to advancing a portfolio of next-generation therapies, with individualized dosing regimens and delivery options to address the escalating disease burden of addiction faced by patients, families, healthcare professionals, payers and society.

As the Committee and Congress take up the august task of reauthorizing the SUPPORT Act, Braeburn asks that lawmakers build upon its solid foundation and take what has been learned over the past five years as a guide. As the opioid epidemic has evolved, traversed the COVID-19 global public health emergency and been reshaped by fentanyl and other synthetic drugs, the reauthorization of the SUPPORT Act will reinvigorate and realign the Nation's approach to treatment and recovery to the needs and realities of today's OUD patient population.

Barriers to substance use treatment and recovery must be eliminated to make the SUPPORT Act work better for patients and health care providers. The programs rooted in the SUPPORT Act and its reauthorization that this Congress will consider are thwarted if a patient encounters administrative, regulatory, and financial barriers when they seek to access treatment services. These barriers include unworkable utilization management of MOUD, loss of Medicaid benefits for those in correctional settings, and coverage determinations for innovative therapies.

Utilization Management of Medications for Opioid Use Disorder (MOUD)

Medicaid is the single largest payer of OUD treatment, covering thirty-eight percent (38%) of all nonelderly adults with OUD. For this reason, Section 1006B of the SUPPORT Act required Medicaid programs nationwide to cover all MOUD therapies. This mandate is set to expire at the 2025 fiscal year. Reauthorization of the SUPPORT Act must, at a minimum, include an extension of this mandate or a provision to make it permanent. The Committee's consideration of HR 3736 to extend this requirement through 2035, is a valuable step in the effort to reauthorize the SUPPORT Act.

Along with extending or making permanent the requirement that Medicaid programs cover all FDA-approved MOUD, SUPPORT Act reauthorization must reign in utilization management techniques applied in Medicaid, such as prior authorization (PA). A person seeking recovery from OUD is extremely fragile. If they encounter an obstacle – logistical, administrative, physical, emotional, financial, etc. -- it could spur them to abandon treatment and push them into a relapse. Prior authorization is such an obstacle that blocks, hinders and delays access to MOUD for a significant number of patients seeking treatment. According to the National Health Law Program, PA for buprenorphine is required by 40 state Medicaid programs. The utilization management techniques used by state Medicaid programs determine if, when, and how MOUD is accessed by a sizable portion of people living with OUD. If our nation is going to turn the tide on OUD, Medicaid programs must be at the forefront of the transformation.

In 2018, CMS limited the use of PA for buprenorphine MOUD products in Medicare. The Journal of the American Medical Association reported that implementation of this policy has been linked to increased

access to buprenorphine, a decrease in SUD-related hospital admissions and ED visits, and a decrease in the likelihood of relapse among OUD patients. It is past time for similar prior authorization guardrails to be established in Medicaid to preserve timely access to MOUD that physicians prescribe for Medicaid patients.

As the Committee works to reauthorize the SUPPORT Act, among the Committee's highest priorities should be inclusion of legislative language that eliminates burdensome utilization management of MOUD in Medicaid.

Continuity of Care for Justice System Impacted Populations

Individuals with substance use disorder tend to cycle through correctional facilities due to dependency on and repeated use of opioids. Medicaid benefits are terminated when a person is imprisoned. Once released from a correctional setting, a person can (re)apply for Medicaid benefits. There is often a lapse in treatment while benefits are (re)certified. This lapse has serious consequences. Tragically, this is substantiated by a New England Journal of Medicine study that found during the first two weeks following reentry, there is an increase in relative odds of fatal overdose given disconnection from community-based care.

To preserve continuity of care as a person is reintegrating into the community following incarceration, the SUPPORT Act reauthorization should grant states the flexibility to extend Medicaid eligibility prior to release whereby upon release a person would have coverage of MOUD, SUD treatment, and experience less disruption of treatment and recovery support. An example of how this can be achieved is the Medicaid Reentry Act (HR 955/S 285). It is designed to allow states to restart Medicaid coverage for Medicaid-eligible individuals who are incarcerated, up to 30 days before release from jail or prison.

In the same realm, Braeburn calls the Committee's attention to the Due Process Continuity of Care legislation (HR 3074/S 971). This measure targets Medicaid enrolled pretrial detainees, individuals who are incarcerated pending disposition of charges against them. They have not been tried and found guilty of a violation, yet their Medicaid coverage is dropped while awaiting trial. This disrupts continuity of care and may interrupt OUD treatment. This instability in treatment may feed a vicious cycle: arrest – loss of Medicaid benefits due to arrest – release on bail or charges dropped – interruption of OUD treatment due to loss of benefits – relapse of drug use – arrest.

If Congress intends for the billions of dollars it authorizes to make a substantive impact on our nation's opioid epidemic, let's be honest about the people and places that need sustained attention. Politics, prejudice, preconceived feelings toward those in the legal system must be set aside for the sake of treatment and recovery support.

Innovative Therapies

According to the NIH, nearly three million people in the U.S. live with OUD. OUD is a brain disease, not a moral failing. Braeburn continues to challenge the status quo and champion transformation of the management of OUD.

During SUPPORT Act reauthorization efforts, patient access to evidence-based treatment including new formulations of long-acting injectable buprenorphine should be equalized across Medicaid, Medicare and

private health plans. Measures that would remove barriers to access to opioid treatments and recovery support services in Medicare, Medicaid and private insurance, and ensure continuity of care, such as the MORE Savings Act (H.R. 1620/S. 818), would provide a wider entryway to recovery for those seeking care.

Conclusion

The path to our nation's recovery from the nearly decade-long opioid use epidemic is neither straight nor easy. There have been obstacles along the way, but we must persevere for the sake of patients with substance use disorders and their families. Through reauthorization of the SUPPORT Act, we keep climbing toward better treatment options, care that meets the individual where they are, dignity for those whose lives will never be the same because of SUD, sustained recovery, and admiration for the passion shown by each link in the chain that is the comprehensive response to the epidemic.

June 20, 2023

Dear Representative Michael Burgess and Representative Ritchie Torres:

I am writing in support of the Improving Mental Health and Drug Treatment Act (H.R. 3892).

The Medicaid Institutions for Mental Disease (IMD) exclusion is an outdated, discriminatory federal rule that creates significant barriers to treatment for adults with severe mental illness. Under this rule, Medicaid payments to states are prohibited for non-geriatric adults receiving psychiatric care in a treatment facility with more than 16 beds.

H.R. 3892 extends the average length of stay requirements for Medicaid payments in IMDs from 30 to 45 days, providing additional support to states to allow individuals with SMI to stay in an inpatient hospital bed long enough to stabilize, rather than being discharged "quicker but sicker." While Treatment Advocacy Center supports full repeal of the IMD exclusion, H.R. 3892 will assist in supporting quality treatment for people with serious mental illness who need inpatient care.

Treatment Advocacy Center is a national nonprofit dedicated exclusively to eliminating barriers to the timely and effective treatment of serious mental illnesses such as schizophrenia and bipolar disorder. Our organization promotes laws, policies, and practices for the delivery of psychiatric care and supports the development of treatments for and research into the causes of serious mental illnesses.

Sincerely,

Elizabeth Hancq, Director of Research Treatment Advocacy Center

Lisa Daily, Executive Director Treatment Advocacy Center

200 North Glebe Road, Suite 801
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703-294-6001
treatmentadvocacycenter.org

Bipartisan Policy Center Action

June 20, 2023

The Honorable Cathy McMorris Rodgers
Chair
U.S. House Committee on Energy and Commerce
2188 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
U.S. House Committee on Energy and Commerce
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chair
Subcommittee on Health
U.S. House Committee on Energy and Commerce
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
Subcommittee on Health
U.S. House Committee on Energy and Commerce
272 Cannon House Office Building
Washington, DC 20515

Dear Representatives McMorris Rodgers, Pallone, Guthrie, and Eshoo,

Thank you for your leadership in advancing the reauthorization of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act and for scheduling a legislative hearing on June 21, 2023, titled "Responding to America's Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT Act." In advance of this week's legislative hearing, the Bipartisan Policy Center Action (BPC Action) wanted to express our support for the committee's bipartisan efforts to reauthorize the SUPPORT Act and to highlight a few comments that we would encourage you to consider. In addition to providing some overarching concepts of how to optimize federal funding to fill gaps in addiction services, these comments will also highlight areas of support or requested improvements related to specific bills under consideration.

**Overarching concern.** As evidenced by the significant rise in drug overdose deaths, one overarching goal of Congress should be to better direct federal funding toward filling gaps in services for addiction prevention, treatment, harm reduction, and recovery. BPC Action recognizes that addiction is a complex disease, but Congress can help ensure effective services are available to limit preventable lives lost. We recommend that Congress establish a process for launching and evaluating demonstration grants through agencies such as the Centers for Medicare and Medicaid (CMS) and the Substance Abuse and Mental Health Services

Administration (SAMHSA). The rationale for this is simple: The SUPPORT Act has authorized various demonstration programs that, while addressing gaps in services, may not be effective. Congress should ensure that these programs are evaluated; programs showing effectiveness can expand, while less or ineffective programs can sunset. To aid in this effort, BPC outlined specific demonstration programs which Congress can evaluate and/or consolidate (see Appendix).

Congress can direct the White House Office of National Drug Control Policy (ONDCP) to spearhead this effort. Because ONDCP has the authority to coordinate across the executive branch, it is well-positioned to reduce government-wide fragmentation by guiding agencies according to service needs. ONDCP can ensure agencies with complementing expertise that manage similar programs across the government coordinate to maximize their resources. Similarly, ONDCP can track spending across these and other opioid-related programs, as proposed in H.R. 679 during the 117th Congress. BPC has categorized and identified programs that address aspects of the drug overdose crisis, and tracked spending for these programs over multiple years. ONDCP can establish and sustain partnerships across the federal government to enhance program management, data collection, and evaluation capacity to increase the likelihood that these demonstration programs achieve their overall goals of preventing overdose deaths.

**Specific legislation.** BPC Action appreciates the opportunity to provide some comments pertaining to some of the legislative proposals in front of the Committee, including H.R. 2400, the Reentry Act; H.R.3074, the Due Process Continuity of Care Act; H.R. 3892, the Improving Mental Health and Drug Treatment Act; H.R. 4091, the Combatting Substance Use Disorder Act; H.R. 3736, the Extending Access to Addiction Treatment Act; H.R. 4100, amending the Public Health Service Act to reauthorize a monitoring and education program regarding infections associated with illicit drug use and other risk factors; and H.R. 4101, the Road to Recovery Act. BPC Action has also advocated for provisions strengthening the workforce, and thus supports H.R. 4079, the Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthorization Act of 2023; and H.R. 4097, the Mental Health Improvement Act.

BPC Action is supportive of the goals and objectives of the Reentry Act, which stems from the original SUPPORT Act that required CMS to convene a stakeholder workgroup in order to develop best practices for states to help transitioning inmates ensure continuity of Medicaid coverage. Though CMS took the crucial step of issuing guidance to encourage states to adopt this policy using their Section 1115 waivers, the Reentry Act is the natural next legislative step. By allowing all states to provide pre-release care to Medicaid eligible individuals up to 30 days prior to release from incarceration, the Reentry Act would set an important minimum federal standard. Wait times for reinstating Medicaid coverage can last months, leaving formerly incarcerated individuals uninsured and at risk of dying of drug overdoses and suicides. Already, the Reentry Act has gotten broad bipartisan support, with nearly 35 cosponsors, including 23 Democrats and

12 Republican. The Reentry Act would result in long-term savings, ensuring economic productivity.

Similarly, BPC Action applauds the Committee on the Due Process Continuity of Care Act. We believe this would restore access to lifesaving treatment while translating to savings in federal funding; with federal funding being cut off to inmates in correctional facilities, the costs of care—an estimated $3.34 billion—falls onto local jails and taxpayers.

Additionally, BPC Action is supportive of the Improving Mental Health and Drug Treatment Act repeals a longstanding restriction prohibiting federal payment under Medicaid for services provided in institutions for mental diseases (IMDs) for individuals under the age of 65. Known as the "IMD exclusion," this law has resulted in limited hospital capacity for psychiatric beds, leaving people experiencing mental health crises and overdoses to deal with their conditions on their own. States were recently granted the option to cover short-term stays in psychiatric hospitals under Medicaid, but there is currently no federal standard. This scenario represents a missed opportunity for initiating treatment for the highest risk subset of patients. BPC Action supports this bill, and recommends adding guardrails to ensure pediatric mental health and addiction patients are not unnecessarily institutionalized at higher rates. Furthermore, we recommend including processes for reporting utilization, assessing outcomes, and promoting transparency for the general public.

Because BPC Action has advocated for improved reporting requirements, we are supportive of the Combatting Substance Use Disorder Act which expands the data collected through the T-MSIS. We recommend that Congress direct the HHS secretary to collect a subset of metrics that measure health care service delivery for addiction care: engagement in care, treatment initiation, retention, and remission. We also recommend that the HHS secretary direct CMS to collect five additional recovery-focused metrics that are currently collected through SAMHSA's Treatment Episode Data Set (TEDS) system: employed/in school full time or part time; in stable housing/living situation; without arrests in prior 30 days; drug use abstinence; and attending social support of recovery programs. Agencies would be able to use these data to assess and evaluate the effectiveness of federally funded interventions on patient care.

BPC Action generally advocates for more efficiency and consistency across the federal government. To that end, we applaud the Committee's inclusion of the Extending Access to Addiction Treatment Act, which extends the requirement for state Medicaid plans to cover medication-assisted treatment through 2035. BPC recommends that the Committee include a provision encouraging state Medicaid agencies and single state agencies (SSAs) which receive SAMHSA funding to coordinate and fill gaps in Medicaid coverage.

Bipartisan Policy Center Action

BPC Action supports the availability of harm reduction services that prevent overdose deaths, and especially supports amending the Public Health Service Act to reauthorize a monitoring and education program regarding infections associated with illicit drug use and other risk factors, the Road to Recovery Act, which would reauthorize national peer-run training and technical assistance for addiction recovery support. We recommend that the Committee consider adding a provision that will enhance technical assistance and data collection to support establishing national core certification requirements for peers.

While BPC Action is thrilled to see these bills included in the SUPPORT Act, we do not support H.R. 824, the Telehealth Benefit Expansion for Workers Act of 2023 because of the potential to fragment care delivery. The pandemic-related telehealth flexibilities created opportunities for fully virtual providers who do not have brick-and-mortar locations to deliver services to Medicare beneficiaries and receive reimbursement. While these alternative types of providers can expand Medicare beneficiaries' access to services, stand-alone telehealth providers and stand-alone telehealth plans can further fragment care. We recommend a comprehensive approach to care delivery that allows for all modalities, including in-person care with options for virtual care.

We commend the Subcommittee for its ongoing efforts to tackle these critical issues in a bipartisan manner and thank you for your consideration of these comments and suggestions.

Sincerely,

Andrew Hu
Director, BPC Action

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Washington, D.C. 20005
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NASMHPD
National Association of State Mental Health Program Directors
675 N. Washington St., Suite 470, Alexandria, VA 22314 (703) 739-9333 Fax (703) 548-9517

June 15, 2023

The Honorable Michael Burgess
2161 Rayburn House Office Bldg.
Washington, D.C. 20515

The Honorable Richie Torres
1414 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Dr. Burgess and Rep. Torres,

The National Association of Mental Health Program Directors (NASMHPD)—the organization representing the state executives responsible for the public mental health service delivery systems in 50 states, 6 territories, and the District of Columbia—is writing to thank you for your bipartisan leadership in introducing the Improving Mental Health and Drug Treatment Act. The state mental health authorities support the legislation, and we will work closely with you to secure congressional action on this important measure.

NASMHPD has long believed that the current Medicaid exclusion for services provided in Institutions for Mental Disease (IMDs) is discriminatory and should be repealed. This policy – which prohibits reimbursement for care provided to adults in inpatient psychiatric hospitals and other inpatient facilities with more than sixteen (16) beds -- is not based on concerns about individual Medicaid eligibility, the medical necessity of services provided, the appropriateness of the service setting, or the quality of care provided. Nor does the policy reflect system trends over the last four decades dramatically reducing the use of inpatient care and the length of inpatient stays.

While not repealing the IMD prohibition, the Improving Mental Health and Drug Treatment Act seeks to provide more permanent Medicaid financing for residential treatment facilities serving persons with substance use disorders while improving coverage for adults seeking care in inpatient psychiatric hospitals through existing Medicaid waiver authorities. It is our hope that passage of this important measure will facilitate approval by the Center for Medicare and Medicaid Services (CMS) of Section 1115 waivers that propose to expand access to inpatient services for Medicaid recipients in need of this level of care.

Finally, the launch of the 988 National Suicide Prevention Lifeline has been a significant success, but utilization of the new three-digit number has been extraordinary. Therefore, NASMHPD recommends either regulatory or legislative action to deem 72-hour crisis receiving/stabilization programs exempt from the IMD exclusion. These programs and their purpose are to stabilize individuals in crisis without unnecessary emergency department admissions, while diverting away from law enforcement and jail, as well as diverting away from higher levels of service and cost with inpatient psychiatric hospital admissions.

Thank you for your attention to these important matters.

Sincerely,

Brian M. Hepburn, M.D.
Executive Director
National Association of State Mental Health Program Directors (NASMHPD)

Schizophrenia & Psychosis Action Alliance

2308 Mount Vernon Ave. Suite 207 | Alexandria, VA 22301 | (240) 423-9432 | www.sczaction.org

June 21, 2023

The Honorable Michael Burgess
2161 Rayburn House Office Bldg.
Washington, D.C. 20515

The Honorable Richie Torres
1414 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Rep. Burgess and Rep. Torres:

On behalf of the Schizophrenia and Psychosis Action Alliance (S&PAA) – a citizens advocacy organization seeking to create a movement for systemic change to improve care, support, and equity for millions of people living with schizophrenia and psychosis spectrum disorders -- I am writing to express our strong endorsement of the bipartisan Improving Mental Health and Drug Treatment Act.

Schizophrenia and psychosis spectrum disorders are neurobiological brain illnesses. These conditions are associated with extraordinary rates of mortality and morbidity along with a high lifetime incidence of suicide. In July 2021, S&PAA released a report identifying the staggering direct and indirect costs of caring for people living with schizophrenia in the United States. The research underscores our country's devastating failure to provide appropriate medical care for people living with schizophrenia, highlighting the urgent need for policy changes to promote comprehensive solutions. Specifically, the report entitled the *Societal Costs of Schizophrenia and Related Disorders* found that the total cost impact of schizophrenia is $281 billion per year with the per capita sending for this patient population in excess of $30,000 annually.

In our view, the 1965 Medicaid Institution for Mental Diseases (IMD) payment exclusion -- which prohibits reimbursement for care provided to adults in inpatient psychiatric hospitals and other inpatient facilities with more than sixteen (16) beds – bears significant responsibility for the catastrophic outcomes revealed in S&PAA's 2021 cost report. In particular, the IMD has manufactured an artificial scarcity of public and private psychiatric hospital beds resulting in sky high utilization of hospital emergency departments among persons with severe mental illnesses. In fact, the American College of Emergency Physicians (ACEP) reports a persistent "boarding crisis" in hospital emergency rooms with individuals in psychiatric crisis boarding for hours, days or weeks while searches are conducted to find appropriate inpatient placements. The IMD has also directly contributed to both the "re-institutionalization" of the mentally ill in state prisons and county jails as well as a side-by-side homelessness crisis impacting major metropolitan areas from New York City and Los Angeles to San Francisco and Washington, D.C.

The Improving Mental Health and Drug Treatment Act takes important steps to address these problems by providing an opportunity for states to shift reimbursements for residential treatment centers for persons with substance use disorders to more permanent financing mechanisms while improving coverage for adults seeking care in psychiatric hospitals through existing Medicaid waiver authorities. While considering your legislation, we hope that Congress will also seek to examine and reform the existing byzantine process whereby vital inpatient care for persons with serious mental disorders are funded through a series of Medicaid "experimental" Section 1115 waivers and opaque side deals with managed care organizations. Under the Medicaid program, inpatient hospital care is not considered "experimental" for patients with cancer, heart disease and diabetes. The fact that psychiatric hospitalization for patients in need of that level of care has to financed through a disjointed series of complex and temporary "experimental" waivers underscores the second-class status of persons with schizophrenia and helps to explain the terrible clinical outcomes for these patients.

Again, thank you for your leadership.

Sincerely,

Gordon Lavigne, M.Ed.
CEO
Schizophrenia & Psychosis Action Alliance

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

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June 20, 2023

***DELIVERED VIA EMAIL***

The Hon. Cathy McMorris Rodgers, Chair
U.S. House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Hon. Frank Pallone, Ranking Member
U.S. House Committee on Energy & Commerce
2322 Rayburn House Office Building
Washington, DC 20515

The Hon. Brett Guthrie, Chair
Subcommittee on Health
U.S. House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Hon. Anna Eshoo, Ranking Member
Subcommittee on Health
U.S. House Committee on Energy & Commerce
2322 Rayburn House Office Building
Washington, DC 20515

The Hon. Larry Bucshon, MD, Vice Chair
Subcommittee on Health
U.S. House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

**RE: Permanently Extend Section 5052 of the SUPPORT Act to Waive the IMD Exclusion and Provide Access to Needed Care for Americans Struggling with Substance Use Disorders**

Dear Chairwoman Rodgers, Ranking Member Pallone, Chairman Guthrie, Vice Chairman Bucshon, Ranking Member Eshoo, and distinguished members of the Committee:

The Pyramid Healthcare, Inc. ("Pyramid Healthcare") family of companies urges you to permanently reauthorize and extend the SUPPORT Act,[1] specifically Section 5052 related to a "[s]tate option to provide Medicaid coverage for certain individuals with substance use disorders who are patients in certain institutions for mental diseases." Furthermore, we encourage you to amend the Act to remove the 30-day limit per 12 month period and ultimately create a pathway to completely eliminate the IMD Exclusion. The SUPPORT Act will expire September 30, 2023 unless Congress acts now to reauthorize it.

As background, Pyramid Healthcare was founded in Pennsylvania in 1999 and is an integrated behavioral healthcare system that employs over 3,100 professionals caring for 12,000 unique commercial and Medicaid patients per day throughout our over 80 residential and outpatient treatment locations in 8 states. We offer a treatment continuum providing comprehensive behavioral healthcare specialties, including: substance use disorder, mental health, autism, and eating disorder treatment.

[1] Pub. L. No. 115-271 (2018), *available at* https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf.

**Permanently Extend Section 5052 of the SUPPORT Act to Continue IMD Exclusion Waiver Authority**

The Social Security Amendments Act of 1965 created Medicare and Medicaid and also created the so-called "institutions for mental disease" ("IMD") exclusion, which barred states from using Medicaid funds to pay for treatment in psychiatric hospital or residential treatment facility settings with 16 or more beds in the facility in order to avoid unnecessarily institutionalizing people with mental health and substance use treatment issues. The world has changed much since then. The behavioral health treatment industry has become professionalized with national accreditation and state/federal regulatory oversight to assure clinical quality and client outcomes which renders the reasons for the IMD exclusion outdated.

The exclusion is currently a major barrier to providing access to care for crucial populations. Research has shown that the majority of people who need behavioral healthcare do not get it. The IMD exclusions is but one of the reasons. Additionally, with current low Medicaid reimbursement rates for residential mental health and substance use treatment services, the low resulting low margins require that providers achieve scalability to operate sustainable programs. This is not possible with the IMD exclusion.

Congress agreed when it passed originally passed Subtitle F of the SUPPORT Act containing Section 5052, which added "a new state plan option, beginning October 1, 2019, and ending September 30, 2023, to provide Medicaid coverage of Medicaid enrollees aged 21 through 64 with at least one SUD who are patients in an eligible IMD for no more than a period of 30 days (whether or not consecutive) during a 12-month period."[2]

**Amend the SUPPORT Act to Remove 30-day per 12 Month Period Limit**

As part of Congress' reauthorization of the IMD exclusion waiver authority, we urge an amendment to remove the artificial limit of 30-days of federal reimbursement per twelve month period at IMDs that several states utilize. Addiction and mental illness are chronic diseases, subject to periods of acuity and relapse. It is not uncommon for an individual Medicaid recipient with mental health or substance use treatment issues to require repeat bouts of care during the course of a year in order to achieve lasting stability and recovery. This restriction does not reflect the current medical understanding of addiction and represents an artificial restriction on access to care and successful outcomes. It should be eliminated.

**Eliminate the IMD Exclusion**

Once again, over 100,000 Americans died from drug overdoses in the 12 month period ending January 2023, primarily from synthetic opioids such as fentanyl.[3] Substance use disorder is the only chronic disease for which there exists artificial and discriminatory limits on care. As a result, ultimately, the IMD exclusion should be completely repealed.

We understand that the fiscal impact of a full repeal will initially raise federal healthcare spending. The Congressional Budget Office recently evaluated the impact of various IMD exclusion waiver and repeal options.[4] It should be noted, however, that the cost of not treating people is even greater – as we have seen as a nation. Between overcrowded emergency departments and overburdened healthcare, social service and criminal justice infrastructure, as well as expanding homeless populations, many states have sought and received IMD waivers because they realized they did not have enough services to meet the demand. According to the behavioral healthcare industry research organization, OPEN MINDS, "[a]s of December 2022, 34 states and the District of Columbia, representing 73% of the Medicaid enrollees ages 21 to 64, had a section 1115 waiver" related to flexibilities of the IMD exclusion. The time has thus come to completely eliminate this vestige of a bygone age.

[2] IN FOCUS: "Medicaid's Institutions for Mental Disease (IMD) Exclusion," Congressional Research Service (Updated July 30, 2019) at 2, available at https://crsreports.congress.gov/product/pdf/IF/IF10222.

[3] https://www.reuters.com/world/us/us-drug-overdose-deaths-top-109000-past-year-2023-06-14/.

[4] "Budgetary Effects of Policies to Modify or Eliminate Medicaid's Institutions for Mental Diseases Exclusion," Congressional Budget Office (Apr. 2023), *available at* https://www.cbo.gov/publication/58962.

The default is now for states to waive the IMD exclusion to be able to provide desperately needed services. The time is now for the Federal government to make the same move and eliminate the IMD.

Congress has recently drawn attention to the need to reauthorize the SUPPORT Act. The U.S. House Energy & Commerce Health Subcommittee held a field hearing on June 9, 2023[5] and will hold an upcoming hearing on June 21, 2023 related to the SUPPORT Act and other opioid-related legislation.[6] It is essential that Section 5052 of the SUPPORT Act is permanently reauthorized immediately to ensure Americans with mental health and substance use disorders continue to have access to care in residential treatment settings when appropriate.

Please permanently extend and reauthorize the SUPPORT Act to ensure a robust network of providers across the full continuum of care for Medicaid substance use treatment and recovery services. We also encourage you to amend the legislation to remove the 30-day per 12 month limit and ultimately repeal the IMD exclusion completely. A strong provider network expands access to care Americans and ensures there is enough capacity to treat all who seek care. Thank you for your support of mental health, behavioral health, and substance use providers and for considering our requests on behalf of Pyramid Healthcare. If we can provide any additional information or materials, please contact Collan Rosier, Pyramid Healthcare's Vice President of Government Relations, at crosier@pyramidhc.com or 667-270-1582. In addition, we invite you to reach out and schedule a visit to one of our locations in your state sometime soon.

Sincerely,

Jonathan Wolf
Chief Executive Officer

[5] https://energycommerce.house.gov/events/health-subcommittee-field-hearing-addressing-the-opioid-crisis-examining-the-support-act-five-years-later.

[6] https://energycommerce.house.gov/posts/chairs-rodgers-guthrie-announce-subcommittee-legislative-hearing-on-solutions-to-address-substance-use-disorder-1.

May 31, 2023

The Honorable Bill Cassidy
U.S. Senate
Washington, DC 20510

The Honorable Jeff Merkley
U.S. Senate
Washington, DC 20510

The Honorable Ed Markey
U.S. Senate
Washington, DC 20510

The Honorable Tillis
U.S. Senate
Washington, DC 20510

The Honorable David Trone
U.S. House
Washington, DC 20515

The Honorable John Rutherford
U.S. House
Washington, DC 20515

The Honorable Michael Turner
U.S. House
Washington, DC 20515

The Honorable Paul Tonko
U.S. House
Washington, DC 20515

Dear Senators and Representatives:

The undersigned addiction, mental health, recovery support, harm reduction, and healthcare professional organizations write to voice our strong support for **S. 971/H.R. 3074 – the Due Process Continuity of Care Act**.

As you know, the Medicaid Inmate Exclusion Policy (MIEP) in federal law severely limits Medicaid from paying for healthcare services for individuals who are incarcerated. This includes individuals who are incarcerated pending disposition of charges against them, otherwise known as pretrial detainees. Your bill, the Due Process Continuity of Care Act, would amend the MIEP to allow these otherwise eligible individuals to receive their full Medicaid benefits while incarcerated at the option of the state. While a modified version of the Due Process Continuity of Care Act was included in December's Consolidated Appropriations Act 2023, these provisions only applied to minors.

Individuals who are incarcerated have high rates of chronic diseases, including substance use and mental health disorders, and disproportionately low incomes, meaning many of these individuals qualify for Medicaid coverage.[1] About 65% of individuals who are incarcerated in jails in the U.S. – an estimated 490,000 people -- were awaiting court action on a current charge in 2019.[2] Of note, in the same year, Black Americans were incarcerated in jails at a rate more than three times the

[1] Pew Charitable Trusts. "Can Medicaid Help Improve Opioid Use Disorder Treatment in Correctional Facilities?" Accessed May 18, 2023. https://pew.org/378xw3U.
[2] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. "Jail Inmates in 2019," March 2021. https://bjs.ojp.gov/content/pub/pdf/ji19.pdf.

rate for White Americans.[3] Healthcare coverage while in pretrial detention affects the lives of a considerable number of Americans with substance use disorder (SUD), including opioid use disorder (OUD), and Medicaid coverage for pretrial detainees can save lives from overdose deaths. For these reasons, this is an important area for policy intervention.

Ensuring pretrial detainees maintain their Medicaid coverage is not only commonsense, but it represents an important social justice issue as many pretrial detainees remain in jails simply because they cannot afford financial bail[4] - and would otherwise have access to their healthcare coverage. In this sense, the policy is discriminatory because it allows only those who can post financial bail to maintain their healthcare coverage. Additionally, the application of the MIEP to pretrial detainees puts significant pressure on already strapped local and state budgets, because U.S. jails and prisons have a constitutional obligation to provide inmates with adequate medical care.[5] The denial of Medicaid coverage to pretrial detainees collectively burdens local and state governments with billions of dollars in additional healthcare costs to care for a vulnerable population eligible for federal Medicaid coverage.[6]

Further complicating the problem, individuals who are incarcerated in the U.S. frequently cannot access medications for OUD.[7] For example, studies show that individuals who received buprenorphine in jails had less involvement with the criminal legal system post-incarceration.[8] Passage of the Due Process Continuity of Care Act would likely increase access to these lifesaving medications in jails and reduce recidivism. Your legislation also carefully implements its amendment to the MIEP with the authorization of $50 million in planning grant dollars to states.

In sum, the Due Process Continuity of Care Act is an important step towards reducing rising SUD-related mortality.[9] Its enactment will save lives. The undersigned strongly support swift passage of this legislation, and thank you for your leadership in addressing this important issue.

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[3] Ibid.
[4] Journal, A. B. A. "Justice Reform Advocates Offer a Roadmap for Reforming Pretrial Release." ABA Journal. Accessed May 18, 2023. https://www.abajournal.com/news/article/justice_reform_advocates_offer_a_roadmap_for_reforming_pretrial_release.
[5] *See* Estelle v. Gamble, 429 U.S. 97, 103, 97 S. Ct. 285, 290, 50 L. Ed. 2d 251, 256 (1976) ("These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration.").
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Sincerely,

American Academy of Addiction Psychiatry

American Association for the Treatment of Opioid Dependence

American College of Emergency Physicians

American College of Medical Toxicology

American College of Osteopathic Emergency Physicians

American Foundation for Suicide Prevention

American Osteopathic Academy of Addiction Medicine

American Psychiatric Association

American Psychological Association Services

American Society of Addiction Medicine

A New PATH (Parents for Addiction Treatment & Healing)

Association for Behavioral Health and Wellness

Behavioral Health Association of Providers

CADA of Northwest Louisiana

Faces & Voices of Recovery

HIV Alliance

International Certification & Reciprocity Consortium (IC&RC)

National Alliance for Medication Assisted Recovery

National Association for Behavioral Healthcare

National Association of Addiction Treatment Providers

National Commission on Correctional Health Care

National Council for Mental Wellbeing

National Health Care for the Homeless Council

National Safety Council

Partnership to End Addiction

Shatterproof

SMART Recovery

Stop Stigma Now

Student Coalition on Addiction

The Kennedy Forum

Treatment Communities of America

Young People in Recovery

April 26, 2023

The Honorable Charles Schumer
Majority Leader
S-230, U.S. Capitol
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
S-221, U.S. Capitol
Washington, DC 20510

The Honorable Kevin McCarthy
Speaker of the House
H-232, U.S. Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
H-204, U.S. Capitol
Washington, DC 20515

Dear Leader Schumer, Minority Leader McConnell, Speaker McCarthy, and Minority Leader Jeffries,

On behalf of the undersigned organizations, we write to respectfully request your support for bipartisan, bicameral legislation that amends the Medicaid Inmate Exclusion Policy (MIEP) to improve care coordination and provide continued access to federal health benefits for eligible individuals in local jails. The MIEP, outlined under Section 1905(a)(A) of the Social Security Act, makes no distinction between individuals housed in jails versus prisons and thus unfairly denies or revokes federal health benefits for those being housed in local jails prior to conviction. These individuals, who are pending disposition, are still presumed innocent under the United States Constitution.

The MIEP causes disruptions in health care access for justice-involved populations that are enrolled in federal programs such as Medicaid, Medicare or the Children's Health Insurance Plan (CHIP). This discontinuity in care contributes to detrimental health outcomes and increased rates of recidivism for both individuals and their communities, particularly for the over 63 of jail inmates with a substance use disorder, and the over 50 percent of jail inmates with a diagnosed mental illness. By contrast, uninterrupted health care for those who enter the criminal justice system helps to break the cycle of recidivism exacerbated by untreated physical and mental illnesses, and substance use disorders.

We urge your support for two key bills to address the MIEP, which have been reintroduced in both the U.S. Senate and House of Representatives:

- **Due Process Continuity Care Act (S. 971):** Introduced by Sens. Bill Cassidy, M.D. (R-La.), Jeff Merkley (D-Ore.), Thom Tillis (R-N.C.) and Ed Markey (D-Mass.), the bill would allow pre-trial detainees to receive Medicaid benefits at the option of the state and provide planning grant dollars to states for implementation.

- **Reentry Act (H.R. 2400/S. 1165):** Introduced by Reps. David Trone (D-Md.), Paul D. Tonko (D-N.Y.), Mike Turner (R-Ohio) and John Rutherford (R-Fla.), the bill would allow Medicaid payment for medical services furnished to an incarcerated individual during the 30-day period preceding

the individual's release. The bill has also been introduced in the Senate (S.1165) by Senators Tammy Baldwin (D-WI), Mike Braun (R-IN), Sherrod Brown (D-OH), and J.D. Vance (R-OH).

Our organizations stand ready to work with you to pass these critical pieces of legislation. Consistent and coordinated federal health benefits for individuals would allow for improved care, lower costs to taxpayers and long-term government expenditure, decreased crime, reduced recidivism, improved public safety and better outcomes for the overall health of our residents.

Thank you for your leadership and continued commitment to ensuring counties have the resources necessary to improve the lives of our residents.

Sincerely,

Matthew D. Chase,
Executive Director and CEO
National Association of Counties (NACo)

Jonathan F. Thompson
Executive Director and CEO
National Sheriff's Association (NSA)

Laura Cooper
Executive Director
Major Cities Chiefs Association

Megan Noland
Executive Director
Major County Sheriffs of America

CC: Senator Bill Cassidy
Senator Jeff Merkley
Senator Ed Markey
Senator Tammy Baldwin
Senator Mike Braun
Senator Sherrod Brown
Senator J.D. Vance
Representative David Trone
Representative Paul D. Tonko
Representative Mike Turner
Representative John Rutherford

AMERICAN ACADEMY OF FAMILY PHYSICIANS

June 21, 2023

The Honorable Brett Guthrie
Chairman
House Energy and Commerce Committee,
Health Subcommittee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
House Energy and Commerce Committee,
Health Subcommittee
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to thank the Subcommittee for their focus on improving access to substance use disorder treatment with today's legislative hearing titled "Responding to America's Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT Act."

Family physicians provide comprehensive mental health services and are a major source for mental health care in the U.S. Nearly 40 percent of all visits for depression, anxiety, or cases defined as "any mental illness" were with primary care physicians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with comorbidities.[i] Family physicians also play a crucial role in safe pain management prescribing practices, screening patients for opioid use disorder (OUD), and prescribing and maintaining treatment of medications for OUD (MOUD). Primary care physicians are often the first point of care for patients and can provide necessary referrals or coordinate care with psychiatric and other mental health professionals when needed.

Unfortunately, access to mental health care and substance use disorder (SUD) treatment remains a significant challenge for many patients across the country, particularly those from underserved communities or marginalized populations. The AAFP shares your commitment to advancing policies that will improve access to care for SUD for all communities across the country. We long advocated for elimination of the X-waiver and applaud Congress for doing so as part of the Consolidated Appropriations Act of 2023. Removing these burdensome requirements for physicians to prescribe MOUD will greatly improve patient access to evidence-based, lifesaving treatment.

To build upon this momentum, we offer the following feedback on some of the bills before the Subcommittee.

**Telehealth Policies that Promote Comprehensive, Coordinated Care**

The Academy supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. Telehealth technologies can enhance patient-physician collaborations, increase access to care,



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improve health outcomes, and decrease costs when utilized as a component of, and coordinated with, longitudinal care. Any permanent expansion of telehealth benefits should be structured to not only increase access to care but also promote high-quality, comprehensive, continuous care, as outlined in the joint principles for telehealth policy put forward by the AAFP, the American Academy of Pediatrics and the American College of Physicians.

**We are concerned that the Telehealth Benefit Expansion for Workers Act (H.R. 824) expands telehealth services – beyond just mental and behavioral health – in isolation without any regard for previous physician-patient relationship, previous medical history, or the eventual need for a follow-up in-person examination.** This has the potential to undermine increase fragmentation of care and lead to the patient receiving suboptimal care. We strongly encourage the Committee to instead advance policies that improve access to comprehensive, coordinated, and continuous care while promoting the existing patient-physician relationship and removing remaining barriers for patients to access care through the most appropriate modality.

**Improved Access to SUD Treatment for Justice-Involved Populations**

Individuals who have been incarcerated have significant health care needs and face multiple barriers to obtaining health insurance and access to care. These challenges affect not only the formerly incarcerated individuals, but also their families and communities, many of which are disadvantaged, and experience health inequities born out of complex social determinants of health.

It is estimated that nearly half (47 percent) of individuals who are incarcerated meet the Diagnostic and Statistical Manual (DSM)-IV criteria for substance use disorder in the 12 months prior to admission to prison.[ii] Unfortunately, only 12 to 15 percent of individuals who have a substance use disorder receive drug treatment while incarcerated.[iii] For this reason, individuals who have chronic addictions have a higher risk of going through withdrawal while in custody and then overdosing when they return to the community.[iv,v]

The AAFP advocates for individuals who are incarcerated or detained to have access to comprehensive medical services, including mental health care and substance use disorder treatment. We support the funding and implementation of successful re-entry models and other evidence-based programs to assist those who have recently been incarcerated. Access to evidence-based treatments for SUD should be provided by correctional health facilities while individuals are still incarcerated, and connections to housing, employment, comprehensive primary care, and substance use and mental health support should be made to best support their health outcomes and transition back into the community.

**To that end, the AAFP urges Congress to pass the Reentry Act (S. 1165 / H.R. 2400), which allows Medicaid coverage for incarcerated individuals to automatically begin 30 days prior to their release.** This will facilitate better care continuity as part of community reentry, including for those with SUD and mental health needs.

**The Academy also supports the Due Process Continuity of Care Act (H.R. 3074), which would amend the Medicaid Inmate Exclusion Policy (MIEP) and ensure eligible individuals being detained pre-trial are able to continue receiving SUD treatment.** The impact of incarceration can begin prior to sentencing as people living in poverty are often incarcerated while pending trial due to their inability to pay the cash bond, regardless of their potential threat to society or severity of their alleged crime. In 2019, 65 percent of people who were incarcerated were awaiting trial.[vi] Pre-trial incarceration can last weeks, and sometimes months to years, often disrupting an individual's ongoing SUD treatment and access to care.

**Continued Access to SUD Treatment for Medicaid Beneficiaries**

Finally, the AAFP advocates to expand public and private insurance coverage of MOUD in the primary care setting, with adequate reimbursement for the increased time, staff, and regulatory commitments associated with providing MOUD. Notably, Medicaid enrollees have the highest overall prevalence of mild, moderate, or severe SUD at 21 percent, compared to 16 percent of commercially insured adults.[vii] It is critical that all Medicaid beneficiaries have access to evidence-based, lifesaving treatment for OUD. Therefore, **we are pleased to support the Extending Access to Addiction Treatment Act (H.R. 3736), which would extend the requirement that state Medicaid programs cover MOUD through 2035.**

Thank you for the opportunity to offer these recommendations. The AAFP looks forward to continuing to work with you to advance policies that improve access to care for patients with SUD. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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June 20, 2023

The Honorable Cathy McMorris Rodgers
Chairwoman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Brett Guthrie
Chairman
Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Anna Eshoo
Ranking Member
Energy and Commerce Subcommittee
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman McMorris Rodgers, Ranking Member Pallone, Chairman Guthrie and Ranking Member Eshoo:

On behalf of the 1.4 million members of the American Federation of State, County and Municipal Employees (AFSCME), thank you for holding the Subcommittee hearing on "Responding to America's Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT Act" on June 21. I request that you include this letter in the hearing record.

AFSCME members work on the front lines in public safety, social services and behavioral health and primary health care. They bear witness to the devasting impact that addiction has on individuals, families and communities. According to data from the Center for Disease Control and Prevention, more than 107,000 Americans died from drug overdoses in 2021, a new high for the United States. Deaths from opioid use and synthetic opioids like fentanyl, psychostimulants and cocaine rose from 2020-2021 during the COVID 19 pandemic. A multifaceted approach is needed to prevent overdoses and ensure that front-line workers have the tools to help those in crisis. Passage of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271) in 2018 was a crucial step to help address substance use disorders, but it is not enough.

Addressing our country's mental and behavioral health crisis means supporting the workers who are critical to the health and well-being of our communities. But with growing caseloads, high staff turnover, stagnant pay, unsafe working conditions, and poor outcomes for those in treatment, one thing is clear: Congress must help empower therapists, case managers, peers, as well as support staff and allies, not just the substance use disorder treatment industry. A strong and equitable community behavioral health system can empower people to recover, heal and thrive. We urge Congress to empower workers to improve their working conditions and provide the best possible care for clients.

As you reauthorize these crucial grant programs, we urge you to prohibit behavioral health care providers from using taxpayer funded grants to deter or oppose workers from exercising their freedom to form a union. We also urge you to prioritize providers as recipients of federal substance use disorder treatment and prevention grants that recruit and retain workers by improving working conditions, reducing untenable caseloads, and giving workers a voice on the job for their profession and clients.

We also support several bills which address needed funding in corrections to provide health services and expand Medicaid coverage.

**The Reentry Act (H.R. 2400).** AFSCME supports this bill because it would be a game changer for reducing overdose deaths and suicides by allowing all states to provide pre-release care to Medicaid eligible individuals up to 30 days prior to release from incarceration. AFSCME members who work in corrections face a dire staffing crisis. This influx of federal funds will help provide needed resources to support state and local corrections.

**The Extending Access to Addiction Treatment Act (H.R. 3736).** AFSCME supports this bill which extends the requirement that Medicaid cover addiction medication for Americans who need it. Medication-assisted treatment for addiction significantly reduces the risk of overdose death but despite its effectiveness, roughly 87% of individuals with opioid use disorder who may benefit from this treatment do not receive it.

**The Due Process Continuity of Care Act (H.R. 3074).** AFSCME supports this bill which would help address important health issues by assisting county and local jails who bear the financial burden of health care for pretrial detainees. Roughly two-thirds of people held in local jails are pretrial detainees. The bill authorizes $50 million in planning grants for states. We urge additional funds to help increase staffing in corrections to support these services.

We also reaffirm our support for a loan repayment program targeting professionals and paraprofessionals in the substance use disorder treatment and recovery workforce. AFSCME strongly supports **the Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthorization of 2023 (STAR LRP) (H.R. 4079).** The goal of the STAR LRP is to increase the number of full-time substance use disorder treatment and recovery workers to meet the urgent need for treatment by reducing workers' student loan debt. We urge you to increase the level of authorization to match the level of qualified applicants. While 3,200 applicants are anticipated, there will be only 160 new awards in FY 2023. The current authorization level of $40 million is inadequate to meet the high demand.

**Telehealth Expansion for Workers Act (H.R. 824)**. We are concerned that the Telehealth Expansion for Workers Act (H.R. 824) creates an unnecessary carve-out from existing consumer health protections and standards. Ordinarily, any employer-sponsored plan covering medical services for employees and dependents is subject to the Affordable Care Act (ACA) and other federal standards for group health plans. H.R. 824 would carve out telehealth benefits from all these federal standards which are designed to ensure affordable coverage no matter a person's health status.

While expanding access to telehealth may be a useful goal, H.R. 824 would make telehealth benefits an excepted benefit, and thus reduce, *not enhance*, quality coverage. The bill would allow stand-alone telehealth benefits plans not to play by the rules and not to comply with key consumer protections, such as preventive services without cost-sharing, the ban on charging individuals with pre-existing conditions higher premiums, the ban on annual dollar limits on benefits, mental health parity requirements, and the annual cap on enrollees' out-of-pocket spending. The loss of these and other hard-fought ACA protections is a major step backwards.

Thank you for considering our views. We look forward to working with you to identify bipartisan policy solutions to America's overdose crisis.

Sincerely,

Edwin S. Jayne
Director of Federal Government Affairs

ESJ:DH:ei

cc: Members of the House Energy and Commerce Subcommittee on Health

Bipartisan Policy Center Action

June 20, 2023

The Honorable Cathy McMorris Rodgers
Chair
U.S. House Committee on Energy and Commerce
2188 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
U.S. House Committee on Energy and Commerce
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Chair
Subcommittee on Health
U.S. House Committee on Energy and Commerce
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
Subcommittee on Health
U.S. House Committee on Energy and Commerce
272 Cannon House Office Building
Washington, DC 20515

Dear Representatives McMorris Rodgers, Pallone, Guthrie, and Eshoo,

Thank you for your leadership in advancing the reauthorization of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act and for scheduling a legislative hearing on June 21, 2023, titled "Responding to America's Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT Act." In advance of this week's legislative hearing, the Bipartisan Policy Center Action (BPC Action) wanted to express our support for the committee's bipartisan efforts to reauthorize the SUPPORT Act and to highlight a few comments that we would encourage you to consider. In addition to providing some overarching concepts of how to optimize federal funding to fill gaps in addiction services, these comments will also highlight areas of support or requested improvements related to specific bills under consideration.

**Overarching concern.** As evidenced by the significant rise in drug overdose deaths, one overarching goal of Congress should be to better direct federal funding toward filling gaps in services for addiction prevention, treatment, harm reduction, and recovery. BPC Action recognizes that addiction is a complex disease, but Congress can help ensure effective services are available to limit preventable lives lost. We recommend that Congress establish a process for launching and evaluating demonstration grants through agencies such as the Centers for Medicare and Medicaid (CMS) and the Substance Abuse and Mental Health Services

Administration (SAMHSA). The rationale for this is simple: The SUPPORT Act has authorized various demonstration programs that, while addressing gaps in services, may not be effective. Congress should ensure that these programs are evaluated; programs showing effectiveness can expand, while less or ineffective programs can sunset. To aid in this effort, BPC outlined specific demonstration programs which Congress can evaluate and/or consolidate (see Appendix).

Congress can direct the White House Office of National Drug Control Policy (ONDCP) to spearhead this effort. Because ONDCP has the authority to coordinate across the executive branch, it is well-positioned to reduce government-wide fragmentation by guiding agencies according to service needs. ONDCP can ensure agencies with complementing expertise that manage similar programs across the government coordinate to maximize their resources. Similarly, ONDCP can track spending across these and other opioid-related programs, as proposed in H.R. 679 during the 117th Congress. BPC has categorized and identified programs that address aspects of the drug overdose crisis, and tracked spending for these programs over multiple years. ONDCP can establish and sustain partnerships across the federal government to enhance program management, data collection, and evaluation capacity to increase the likelihood that these demonstration programs achieve their overall goals of preventing overdose deaths.

**Specific legislation.** BPC Action appreciates the opportunity to provide some comments pertaining to some of the legislative proposals in front of the Committee, including H.R. 2400, the Reentry Act; H.R.3074, the Due Process Continuity of Care Act; H.R. 3892, the Improving Mental Health and Drug Treatment Act; H.R. 4091, the Combatting Substance Use Disorder Act; H.R. 3736, the Extending Access to Addiction Treatment Act; H.R. 4100, amending the Public Health Service Act to reauthorize a monitoring and education program regarding infections associated with illicit drug use and other risk factors; and H.R. 4101, the Road to Recovery Act. BPC Action has also advocated for provisions strengthening the workforce, and thus supports H.R. 4079, the Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthorization Act of 2023; and H.R. 4097, the Mental Health Improvement Act.

BPC Action is supportive of the goals and objectives of the Reentry Act, which stems from the original SUPPORT Act that required CMS to convene a stakeholder workgroup in order to develop best practices for states to help transitioning inmates ensure continuity of Medicaid coverage. Though CMS took the crucial step of issuing guidance to encourage states to adopt this policy using their Section 1115 waivers, the Reentry Act is the natural next legislative step. By allowing all states to provide pre-release care to Medicaid eligible individuals up to 30 days prior to release from incarceration, the Reentry Act would set an important minimum federal standard. Wait times for reinstating Medicaid coverage can last months, leaving formerly incarcerated individuals uninsured and at risk of dying of drug overdoses and suicides. Already, the Reentry Act has gotten broad bipartisan support, with nearly 35 cosponsors, including 23 Democrats and

12 Republican. The Reentry Act would result in long-term savings, ensuring economic productivity.

Similarly, BPC Action applauds the Committee on the Due Process Continuity of Care Act. We believe this would restore access to lifesaving treatment while translating to savings in federal funding; with federal funding being cut off to inmates in correctional facilities, the costs of care—an estimated $3.34 billion—falls onto local jails and taxpayers.

Additionally, BPC Action is supportive of the Improving Mental Health and Drug Treatment Act repeals a longstanding restriction prohibiting federal payment under Medicaid for services provided in institutions for mental diseases (IMDs) for individuals under the age of 65. Known as the "IMD exclusion," this law has resulted in limited hospital capacity for psychiatric beds, leaving people experiencing mental health crises and overdoses to deal with their conditions on their own. States were recently granted the option to cover short-term stays in psychiatric hospitals under Medicaid, but there is currently no federal standard. This scenario represents a missed opportunity for initiating treatment for the highest risk subset of patients. BPC Action supports this bill, and recommends adding guardrails to ensure pediatric mental health and addiction patients are not unnecessarily institutionalized at higher rates. Furthermore, we recommend including processes for reporting utilization, assessing outcomes, and promoting transparency for the general public.

Because BPC Action has advocated for improved reporting requirements, we are supportive of the Combatting Substance Use Disorder Act which expands the data collected through the T-MSIS. We recommend that Congress direct the HHS secretary to collect a subset of metrics that measure health care service delivery for addiction care: engagement in care, treatment initiation, retention, and remission. We also recommend that the HHS secretary direct CMS to collect five additional recovery-focused metrics that are currently collected through SAMHSA's Treatment Episode Data Set (TEDS) system: employed/in school full time or part time; in stable housing/living situation; without arrests in prior 30 days; drug use abstinence; and attending social support of recovery programs. Agencies would be able to use these data to assess and evaluate the effectiveness of federally funded interventions on patient care.

BPC Action generally advocates for more efficiency and consistency across the federal government. To that end, we applaud the Committee's inclusion of the Extending Access to Addiction Treatment Act, which extends the requirement for state Medicaid plans to cover medication-assisted treatment through 2035. BPC recommends that the Committee include a provision encouraging state Medicaid agencies and single state agencies (SSAs) which receive SAMHSA funding to coordinate and fill gaps in Medicaid coverage.

Bipartisan Policy Center Action

BPC Action supports the availability of harm reduction services that prevent overdose deaths, and especially supports amending the Public Health Service Act to reauthorize a monitoring and education program regarding infections associated with illicit drug use and other risk factors, the Road to Recovery Act, which would reauthorize national peer-run training and technical assistance for addiction recovery support. We recommend that the Committee consider adding a provision that will enhance technical assistance and data collection to support establishing national core certification requirements for peers.

While BPC Action is thrilled to see these bills included in the SUPPORT Act, we do not support H.R. 824, the Telehealth Benefit Expansion for Workers Act of 2023 because of the potential to fragment care delivery. The pandemic-related telehealth flexibilities created opportunities for fully virtual providers who do not have brick-and-mortar locations to deliver services to Medicare beneficiaries and receive reimbursement. While these alternative types of providers can expand Medicare beneficiaries' access to services, stand-alone telehealth providers and stand-alone telehealth plans can further fragment care. We recommend a comprehensive approach to care delivery that allows for all modalities, including in-person care with options for virtual care.

We commend the Subcommittee for its ongoing efforts to tackle these critical issues in a bipartisan manner and thank you for your consideration of these comments and suggestions.

Sincerely,

Andrew Hu
Director, BPC Action

Bipartisan Policy Center Action

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Appendices

## BPC SUPPORT Act Demonstration Programs

As Congress opts to revisit the role of demonstration programs addressing addiction services, ***the Bipartisan Policy Center urges Congress to thematically categorize and evaluate these grants.*** Congress understands there is a need for efficient, targeted federal spending that fills critical gaps in addiction services, and by categorizing these programs, the Committee has an opportunity to direct agencies to maximize their resources and coordinate in order to fill these gaps in health care services for addiction patients.

The following bills will reauthorize key grant programs:

- H.R. 4054, the Trauma Support and Mental Health in Schools Reauthorization Act
- H.R. 4057, the Keeping Kids Safe Act
- H.R. 4063, the FIND Fentanyl Act of 2023
- H.R. 4079, the Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthorization Act of 2023
- H.R. 4088, the CAREER Act
- H.R. 4089, the Safer Response Act
- H.R. 4092, the Protecting Moms and Infants Reauthorization Act of 2023
- H.R. 4097, the Mental Health Improvement Act
- H.R. 4098, the Communities of Recovery Reauthorization Act
- H.R. 4099, the RECONNECTS Act of 2023
- H.R. 4101, the Road to Recovery Act
- H.R. 1502, the Comprehensive Opioid Recovery Centers Reauthorization Act of 2023

We have identified several key themes that the Committee could use to catalog the grants authorized in the SUPPORT Act:

| | Grant Program | Appropriated Amount | Authorizing Law |
|---|---|---|---|
| Prevention | Sec. 8203*: ONDCP/CDC Reauthorization of Drug-Free Communities (DFC) Program | $102 appropriated in FY2021 and $101.3 in FY2020<br><br>BPC noted $100.5 million awarded to this program in FY2020 | Originally authorized in National Narcotics Leadership Act of 1988 Sec. 1024 |

| | | | |
|---|---|---|---|
| | Sec. 8071*: HUD Pilot Program to Help Individuals in Recovery From a Substance Use Disorder Become Stably Housed | $25 million appropriated in both FY2021 and FY2020<br><br>BPC noted $25 million awarded to this program in FY2020 | Authorized in SUPPORT Act |
| | Sec. 8204: ONDCP/CDC Reauthorization of the National Community Anti-Drug Coalition Institute | $2.5 million appropriated in FY2021 | Originally authorized in National Narcotics Leadership Act of 1988 Title I Subtitle A Chapter 2 |
| Health Services *Note: States can use these programs to fill gaps in Medicaid coverage* | Sec. 7151*: SAMHSA Building Communities of Recovery | $10 million appropriated in FY2021 and $8 million in FY2020<br><br>BPC noted $8 million awarded in FY2020 | Originally authorized PHSA Sec. 547(f) |
| | Sec. 7121: Comprehensive Opioid Recovery Centers | $4 million appropriated in FY2021 | Originally authorized in PHSA Sec. 552 |
| | Sec. 7161: CDC Preventing Overdoses of Controlled Substances | $475.6 million appropriated in FY2021 | Originally authorized in PHSA Sec. 392(d) and 399O; CARA Sec. 102 |
| | Sec. 7002*: SAMHSA First Responder Training | $42 million appropriated in FY2021 and $41 million appropriated in FY2020.<br><br>BPC noted $41 million awarded to this program in FY2020 | Originally authorized in PHSA Sec. 546(h) |
| | Sec. 7062(b): SAMHSA Residential Treatment Programs for Pregnant and Postpartum Women | $32.9 million appropriated in FY2021 | Originally authorized in PHSA Sec. 508 |
| | Sec. 7091: SAMHSA Emergency Department Alternatives to Opioids Demonstration Program | $6 million appropriated in FY2021 | Authorized in SUPPORT Act |
| | Sec. 7141: CDC Reauthorization and Expansion of Program of Surveillance and Education Regarding Infections Associated | $13 million appropriated in FY2021 | Originally authorized in PHSA Sec. 317N(d) |

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| | with Illicit Drug Use and Other Risk Factors<br><br>(F.K.A. Infectious Diseases and the Opioid Epidemic) | | |
| | Sec. 7183: SAMHSA Comprehensive Addiction Recovery through Effective Employment and Reentry (CAREER) Act | $6 million appropriated in FY2021 | Authorized in SUPPORT Act |
| Capacity Building/ Workforce | Sec. 7071: HRSA Loan Repayment Program for Substance Use Disorder Workforce | $16 million appropriated in FY2021 | Originally authorized in PHSA Sec. 781(j) |
| | Sec. 7073(b): HRSA Mental and Behavioral Health Education Training Program | $36.9 appropriated in FY2021 | Originally authorized in PHSA Sec. 756(f) |
| | Sec. 7152: SAMHSA Peer Support Technical Assistance Center | $1 million appropriated in FY2021 | Originally authorized PHSA Sec. 547(e) |
| Children, Families, and Youth | Sec. 7064*: CDC Prenatal and Postnatal Health | Funded through multiple accounts, including:<br><br>• $2.25 million explicitly for Neonatal Abstinence Syndrome<br>• A portion of funding from CDC's Child Health and Development Program (appropriated $65.8 million)<br>• A portion of funding from CDC's Safe Motherhood/Infant Health Program (appropriated $63 million)<br><br>BPC noted $2.3 million awarded to this program in FY2020 | Originally authorized in PHSA Sec. 317L(d) |
| | Sec. 7131: CDC Surveillance and Data Collection for Child, Youth, and Adult Trauma | $5 million appropriated in FY2021 | Authorized in SUPPORT Act |
| | Sec. 7133: SAMHSA National Child Traumatic Stress Initiative | $71.9 million appropriated in FY2021 | Originally authorized in PHSA Sec. 582(j) |

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|---|---|---|---|
| Criminal Justice | Sec. 8206*: DOJ/OJP Reauthorization of Drug Court Program | $83 million appropriated in FY2021 and $80 million in FY2020<br><br>BPC noted $80 million awarded to this program in FY2020 | Originally authorized in Omnibus Crime Control and Safe Streets Act of 1968 Sec. 1001(a)(25)(A) |
| | Sec. 8092*: DOJ/OJP Reauthorization of the Comprehensive Opioid Abuse Grant Program<br><br>Since renamed Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) | $185 million appropriated in FY2021 and $180 million in FY2020<br><br>BPC noted $180 million awarded to this program in FY2020 | Originally authorized in Omnibus Crime Control and Safe Streets Act of 1968 Sec. 1001(a)(27) |
| | Sec. 8207: ONDCP Drug Court Training and Technical Assistance | $3 million appropriated in FY2021 | Originally authorized in ONDCP Reauthorization Act of 1998 Sec. 705(e)(2) |
| Detection and Surveillance | Sec. 7011*: CDC Pilot Program for Public Health Laboratories to Detect Fentanyl and Other Synthetic Opioids | Funded using a portion of funding from CDC's Environmental Health Laboratory (appropriated $66.8 million in FY2020, $67.8 million in FY2021)<br><br>BPC noted $66.8 million awarded to this program in FY2020 (no awards prior) | Authorized in SUPPORT Act |
| | Sec. 8205*: ONDCP Reauthorization of the High-intensity Drug Trafficking Area (HIDTA) Program | $290 million appropriated in FY2021 and $285 million in FY2020<br><br>BPC noted $300 million awarded to this program in FY2020 | Originally authorized in ONDCP Reauthorization Act of 1998 Sec. 707 |

*Note: The asterisk marks programs that the Bipartisan Policy Center has designated as "opioid-related" in previous spending analyses.*

We have also identified several key mandatory programs authorized in the SUPPORT Act:

| Program | Appropriated Amount | Terms | Authorizing Law |
|---|---|---|---|

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|---|---|---|---|
| Sec. 1003: Demonstration Project to Increase Substance Use Provider Capacity Under the Medicaid Program | $50 million for grants and $5 million for report for FY2019 | One-time FY2019 appropriation made in the SUPPORT Act. | SSA Sec. 1903(aa) |
| Sec. 5061: Medicaid Improvement Fund | $31 million total in FY2021 | Appropriation made in the SUPPORT Act was subsequently amended. The FY2021 appropriation is $0. | SSA Sec. 1941 |
| Sec. 6083(a): Expanding Access Under the Medicare Program to Addiction Treatment in Federally Qualified Health Centers | $6 million total for FY2019 | Appropriation made in the SUPPORT Act. | SSA Sec. 1834(o) |
| Sec. 6083(b): Expanding Access Under Medicare Program to Addiction Treatment in Rural Health Clinics | $2 million total for FY2019 | Appropriation made in the SUPPORT Act. | SSA Sec. 1833(bb) |
| Sec. 8082: ACF Improving Recovery and Reunifying Families | $15 million for FY2019 | A one-time appropriation of FY2019 funds was made in the SUPPORT Act. This funding remains available for use through FY2026. No additional funding is authorized. | SSA Sec. 435(e)(5) |
| Sec. 8083: Building Capacity for Family-focused Residential Treatment | $20 million for FY2019 | A one-year discretionary funding authorization was provided for FY2019 (with any funds appropriated to remain available for use through FY2023). No funds were appropriated under this expired authority. | SUPPORT Act |

June 8, 2023

Hon. Kevin McCarthy
Speaker
House of Representatives
H-232, The Capitol
Washington, D.C. 20515

Hon. Hakeem Jeffries
Minority Leader
House of Representatives
H-204, The Capitol
Washington, D.C. 20515

Hon. Chuck Schumer
Majority Leader
S-221, The Capitol
Washington, DC 20510

Hon. Mitch McConnell
Minority Leader
S-230, The Capitol
Washington, DC 20510

Hon. McMorris Rodgers
Chair
House Energy and Commerce Committee
2155 Rayburn House Office Building
Washington, DC 20515

Hon. Frank Pallone
Ranking Member
House Energy and Commerce Committee
2155 Rayburn House Office Building
Washington, DC 20515

Hon. Ron Wyden
Chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Hon. Mike Crapo
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Speaker McCarthy, Majority Leader Schumer, Minority Leader Jeffries, Minority Leader McConnell, Chair McMorris Rodgers, Ranking Member Pallone, Chair Wyden, and Ranking Member Crapo,

The undersigned organizations, representing a diverse group of stakeholders, write today to endorse the *Due Process Continuity of Care Act (H.R. 3074, S.971)*. This critical legislation would allow pre-trial incarcerated individuals to receive medical services supported by Medicaid.

Currently, the "Medicaid inmate exclusion policy" (MIEP) prohibits the use of federal funds and services for medical care for "inmates of a public institution." This policy prevents Medicaid-eligible incarcerated individuals, regardless of whether they have been convicted, from receiving services funded by Medicaid. This means that incarcerated individuals awaiting trial in a jail cannot receive most Medicaid services. The policy also prevents incarcerated veterans from receiving hospital and outpatient care in local jails from the Department of Veterans Affairs.

The MIEP was established in Sec. 1905(a)(A) of the Social Security Act, decades before the current overdose crisis began. Almost sixty years later, the MIEP has become a significant barrier to accessing substance use disorder treatment in correctional facilities. Despite nearly 60% of incarcerated individuals having a substance use disorder, most go untreated.[1] In 2021, just 12% of jails and prisons offered medications for opioid use disorder (MOUD).[2] A recent Bureau of Justice Statistics report on local jails indicated that fatal drug overdoses are the fastest growing cause of death amongst incarcerated

[1] https://www.ojp.gov/ncjrs/virtual-library/abstracts/behind-bars-ii-substance-abuse-and-americas-prison-population
[2] https://prisonopioidproject.org/data/

individuals, and the median time served before a drug or alcohol intoxication death was just one day.[3] According to the *New England Journal of Medicine*, individuals reentering society from incarcerations are 129 times likelier to die of a drug overdose during the two weeks following their release than the general population.[4] FDA approved MOUD, such as buprenorphine and methadone, have been associated with an 80% reduction in overdose mortality risk for the first month post-release. Despite this, most jails and prisons do not provide methadone or buprenorphine for opioid use disorders. [5]

The MIEP can also be linked to our nation's high recidivism rates. Not treating substance use disorder in a correctional setting can contribute to increased chances of returning to illicit drug use upon release, which leads to a greater likelihood of reoffending. If an individual initiates MOUD treatment while in a correctional setting they have a greater chance of continuing care upon reentry, which contributes to a 32% reduction in recidivism rates.[6] Not only will initiating and maintaining care in correctional settings save lives, but it will also have a positive impact on public safety and reducing the cycle of recidivism.

This act is crucial in ensuring an individual's constitutionally protected rights. The MIEP violates the right that an individual is presumed innocent until proven guilty by including pre-trial incarcerated individuals in the definition of "inmate", thus causing them from to lose their Medicaid benefits before having a chance to defend their innocence. The *Due Process Continuity of Care Act* will ensure that access to treatment is maintained while an individual awaits trial.

Our organizations stand unified in our support of the *Due Process Continuity of Care Act* and our belief that increasing access to treatment will improve public health and public safety in our communities. Thank you for your leadership.

If you have any questions, please contact Ryan Greenstein at rgreenstein@advocacyincubator.org.

Sincerely,

A New PATH (Parents for Addiction Treatment & Healing)

Academic Consortium on Criminal Justice Health

ACOJA Consulting LLC

Addiction Professionals of North Carolina

AIDS United

Alcohol & Drug Abuse Certification Board of Georgia

American Association of Psychiatric Pharmacists

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[3] https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf

[4] Ingrid A. Binswanger, M.D., Marc F. Stern, M.D., Richard A. Deyo, M.D., Patrick J. Heagerty, Ph.D., Allen Cheadle, Ph.D., Joann G. Elmore, M.D., and Thomas D. Koepsell, M.D., Release from Prison – A High Risk of Death for Former Inmates, The New England Journal of Medicine, 2007, https://perma.cc/L49X-7MZ7

[5] Lim S, Cherian T, Katyal M, Goldfeld KS, McDonald R, Wiewel E, Khan M, Krawczyk N, Braunstein S, Murphy SM, Jalali A, Jeng PJ, MacDonald R, Lee JD. Association between jail-based methadone or buprenorphine treatment for opioid use disorder and overdose mortality after release from New York City jails 2011-17. Addiction. 2022 Oct 28. doi: 10.1111/add.16071.

[6] Elizabeth A. Evans, Donna Wilson, Peter D. Friedmann, Recidivism and mortality after in-jail buprenorphine treatment for opioid use disorder, Drug and Alcohol Dependence, Volume 231, 2022, https://doi.org/10.1016/j.drugalcdep.2021.109254.

American College of Correctional Physicians

American Jail Association

American Medical Student Association (AMSA)

AMERSA, Inc

Association for Ambulatory Behavioral Healthcare

C4 Recovery Foundation

CADA of Northwest Louisiana

California Consortium of Addiction Programs & Professionals

CASES

Church of Scientology National Affairs Office

Clinical Social Work Association

Community Catalyst

Community Oriented Correctional Health Services

Correctional Leaders Association

Drug Policy Alliance

Due Process Institute

Faces & Voices of Recovery

Families On The Move Of NYC, Inc.

Family Based Services Assoc of NJ

Fox Valley Perinatology

FREDLA (Family-Run Executive Director Leadership Association)

Futures Without Violence

Global Alliance for Behavioral Health and Social Justice

HIV Alliance

International Community Justice Association

Just Detention International

Law Enforcement Leaders to Reduce Crime & Incarceration

Legal Action Center

Montgomery County Federation of Families for Children's Mental Health, Inc.

National Alliance for Medication Assisted Recovery (NAMA Recovery)

National Association for Behavioral Healthcare

National Association of Criminal Defense Lawyers

National Association of State Mental Health Program Directors

National Behavioral Health Association of Providers

National Center for Advocacy and Recovery, Inc.

National Commission on Correctional Health Care

National Council for Mental Wellbeing

National District Attorneys Association

National Health Care for the Homeless Council

National Juvenile Justice Network

North Carolina Formerly Incarcerated Transition Program

North Carolina Psychiatric Association

Operation Restoration

Overdose Crisis Response Fund

Overdose Prevention Initiative

Prison Families Alliance

Prison Policy Initiative

R Street Institute

RuralOrganizing.org Education Fund

TASC, Inc. (Treatment Alternatives for Safe Communities)

The AIDS Institute

The Council of State Governments (CSG) Justice Center

The Fortune Society

The Kennedy Forum

The National Association for Rural Mental Health

The National Association of County Behavioral Health and Developmental Disability Directors

The Police, Treatment, and Community Collaborative (PTACC)

Voices of Community Activists and Leaders- Kentucky

Washington State Community Connectors

Women on the Rise

CC

Congressman David Trone

Congressman Mike Turner

Congressman Paul Tonko

Congressman John Rutherford

Senator Bill Cassidy

Senator Ed Markey

Senator Jeff Merkley

Senator Thom Tillis

Congress of the United States
Washington, DC 20515

June 13, 2023

Chairwoman Cathy McMorris Rodgers
House Energy and Commerce Committee
2155 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member Frank Pallone
House Energy and Commerce Committee, Minority Staff
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman McMorris-Rogers and Ranking Member Pallone:

As the Energy and Commerce Committee drafts the reauthorization of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, we urge the committee to include H.R. 3074, the Due Process Continuity of Care Act, and H.R. 2400, the Reentry Act.

2.3 million Americans are currently incarcerated in federal and state prisons, local jails, and juvenile correctional facilities, and over 95% of all incarcerated individuals will eventually reenter society. According to the National Institute of Health, 85% of the prison population has an active substance use disorder or is incarcerated for a crime involving drugs or drug use.[1] Further, individuals released from incarceration are 129 times more likely to die of a drug overdose during the first two weeks after release.[2]

Ensuring continuity of care to individuals when they exit incarceration is critical to addressing the drug epidemic afflicting the incarcerated community. We urge you to consider including the Due Process Continuity of Care Act, which focuses on ensuring continuity of care for pretrial incarcerated individuals, and the Reentry Act, which allows all states to provide pre-release care to Medicaid eligible individuals up to 30 days prior to release from incarceration. Both of these bills have broad bipartisan and bicameral congressional support, including multiple members from both sides of the aisle on the committee, and are supported by the law enforcement

[1] "Drug Facts: Criminal Justice." National Institute of Drug Abuse. June 2020. https://nida.nih.gov/sites/default/files/drugfacts-criminal-justice.pdf
[2] "Vera: Overdose Deaths and Jail Incarceration." The Vera Institute. Brooklyn, New York 2023. https://www.vera.org/publications/overdose-deaths-and-jail-incarceration/national-trends-and-racial-disparities

community, county governments, and healthcare providers; some of the endorsing organizations include Major County Sheriffs, National Sheriffs Associations, National Associations of Counties, Major County Chiefs Association, American Psychological Association, and the National Alliance on Mental Health.

H.R. 3074, the Due Process Continuity of Care Act

The Medicaid Inmate Exclusion Policy (MIEP), which was established over 60 years ago under Sec. 1905(a)(A) of the Security Act, denies Medicaid to incarcerated individuals. The MIEP not only applies to convicted individuals in prison, but also to those detained while awaiting trial, which comprises approximately two-thirds of people held in local jails. This exclusion policy has become a significant barrier for pretrial detainees accessing substance use disorder treatment while incarcerated awaiting trial. Further, this exclusionary policy conflicts with these pretrial detainees' due process rights because they lose their Medicaid coverage even though they are presumed innocent and have not been adjudicated.

Pretrial detainees have substantially higher rates of mental health conditions and substance use disorders than the general population – roughly 44% of all pre-trial detainees have a mental health condition and 63% have a substance use disorder.[3] Since many mental health conditions and all substance use disorders are chronic, a sudden absence of stabilizing treatment exacerbates these health problems and requires more intensive and costly care later on, which also contributes to re-arrest and increased recidivism. Furthermore, federal health benefits are rarely immediately restored upon release as the process of re-enrollment can be lengthy, often taking upwards of 90 days,[4] which then frequently leads to returning to illicit drug use without stabilizing care. Therefore, ensuring continued access to federal health benefits will not only improve healthcare for pretrial detainees but will also help break the cycle of recidivism caused by untreated mental health conditions and substance use disorder.

The Due Process Continuity of Care Act would address this issue by amending the MIEP to allow states to decide whether to ensure pretrial detainees do not lose Medicaid coverage of health care services.[5] Last year, a piece of this bill applying to juveniles was included as part of the FY23 omnibus, but it remains vital to ensure that all pretrial adults do not lose their Medicaid coverage before they are adjudicated. This bill has broad bipartisan support; there are 25 House

[3] "NACO-NSA Joint Taskforce Report." 2019, National Association of Counties and National Sheriffs Association, https://www.naco.org/resources/featured/naco-nsa-joint-task-force-report-addressing-federal-medicaid-inmate-exclusion-policy

[4] "Applying for Medicaid – Long Term Care Information." 2017, Long Term Care.gov, https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/applying-for-medicaid.html

[5] The Due Process Continuity of Care Act also authorizes $50 million in planning grants to help states implement the new policy. We understand that this provision is politically contentious and are amenable to dropping this portion of the bill if necessary for including the main policy change.

cosponsors of this bill (13 Republicans and 12 Democrats). Senator Cassidy (R-LA) is leading this bill in the Senate with Senators Tillis (R-NC), Merkley (D-OR), and Markey (D-MA).

H.R. 2400, the Reentry Act

After exiting incarceration, the wait times for reinstating Medicaid can last months, leaving formerly incarcerated individuals without any healthcare services during a time where they need it most. Former inmates are also uniquely vulnerable to overdoses due to reduced tolerance for opioids, lack of effective addiction treatment options while incarcerated, & poor care transitions back into the community.

The Reentry Act allows all states to provide pre-release care to Medicaid eligible individuals up to 30 days prior to release from incarceration. This would be a game changer for reducing overdose deaths and suicides. Like the Due Process Continuity of Care Act, this bill has broad bipartisan support; there are 34 House cosponsors of this bill including a dozen Republicans. Sen. Baldwin (D-IL) is leading this bill in the Senate with Senators Braun (R-IN), Vance (R-OH), Capito (R-WV), Brown (D-OH), Whitehouse (D-RI), Welch (D-VT) and Cassidy (R-LA).

Both the Due Process Continuity of Care Act and the Reentry Act will address the drug epidemic afflicting returning citizens and will make our communities safer. Further, we note that according to House Legislative Counsel and the Congressional Research Service, both these bills do NOT expand Medicaid.

Thank you for your consideration of these two bipartisan bills.

Sincerely,

David J. Trone
Member of Congress

Paul Tonko
Member of Congress

Congress of the United States
Washington, DC 20515

John H. Rutherford
Member of Congress

Eleanor Holmes Norton
Member of Congress

Brian Fitzpatrick
Member of Congress

Don Bacon
Member of Congress

Michael R. Turner
Member of Congress

Seth Moulton
Member of Congress

Nancy Mace
Member of Congress

Daniel Meuser
Member of Congress

Jasmine Crockett
Member of Congress

June 20, 2023

The Honorable Cathy McMorris Rodgers,
Chair
Committee on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone Jr., Ranking Member
Committee on Energy & Commerce
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, D.C. 20515

Dear Chair McMorris Rodgers and Ranking Member Pallone,

The undersigned organizations representing mental health and substance use disorder (MH/SUD) patient advocates, providers, and non-profit organizations write today in opposition to the *"Telehealth Benefit Expansion for Workers Act of 2023"* (H.R. 824). The legislation would allow employers to offer workers stand-alone telehealth benefits, which will erode comprehensive MH/SUD coverage and may create additional barriers for individuals to receive treatment. Furthermore, such benefits would not be subject to the protections of the Mental Health Parity and Addiction Equity Act, the landmark bipartisan legislation that President George W. Bush signed into law 15 years ago.

The United States faces a MH/SUD crisis with over 30% of adults reporting symptoms of anxiety and/or depression in 2021, up from 11% in 2019.[1] National data consistently shows that 40% of all people with untreated mental health problems say they did not get treatment because they could not afford it, while another 22% said their insurance plans either did not cover mental health treatment at all or offered insufficient coverage.[2] Approximately 25% of people with untreated SUD say they did not receive care because they did not have health coverage and could not afford cost, and 12% said their plan did not cover SUD treatment or offered insufficient coverage.[3] Further, people with co-occurring disorders were also unlikely to receive treatment for more than one disorder, even though research demonstrates simultaneous coordinated treatment produces better outcomes.[4]

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[1] Mental Health and Substance Use State Fact Sheets. Henry J. Kaiser Family Foundation 2021. https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets.

[2] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2021). *2020 National Survey on Drug Use and Health, Table 8.33B Detailed Reasons for Not Receiving Mental Health Services in the Past Year: Among People 18 or Older with a Perceived Unmet Need for Mental Health Services in the Past Year; by Receipt of Past Year Mental Health Services, Percentages, 2019 and 2020.* Samhsa.gov. https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/NSDUHDetTabs8-33pe2020.pdf

[3] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2023). *National Survey on Drug Use and Health, 2021: Table 5.41B Detailed Reasons for Not Receiving Substance Use Treatment in Past Year: Among People Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment at a Specialty Facility and Who Perceived a Need for Substance Use Treatment in Past Year; Percentages, 2021.* Samhsa.gov. https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect5pe2021.htm#tab5.41b

[4] T.M. Kelly and D.C. Daley, "Integrated Treatment of Substance Use and Psychiatric Disorders," *Social Work in Public Health* 28, no. 3-4 (2013): 388-406.

While telehealth has been critical to expanding access to health care services; telehealth cannot simply replace in-person service delivery. Individuals, in consultation with their providers, must be able to choose whether telehealth or in-person services are most appropriate for their needs. Some plans have implemented strategies to limit consumers' options by offering "telehealth only" or "telehealth first" coverage, which bars or limits access to in-person care. For individuals who need a higher level of outpatient care, residential care, or inpatient care to treat their MH/SUD condition(s), a "telehealth only" option can negatively impact treatment options, further delay an appropriate level of care, and can be a significant financial barrier if individuals find they must pay out-of-pocket for additional services. Further, even for outpatient services, in-person services may be most appropriate depending on an individual's treatment needs.

We cannot support legislation that will significantly weaken fundamental parity and coverage protections for consumers by allowing plans to discriminate against MH/SUD services and cover only a limited set of services. Our experience has been that, when plans are not required to cover the range of health services that individuals need or meet MH/SUD parity requirements, health plans discriminate against individuals with MH/SUD, leaving them without the ability to obtain needed treatment. The result is that such plans effectively shift costs to taxpayers when individuals' conditions and finances deteriorate and they seek services through Medicaid and other public programs. We fear this legislation would supercharge this harmful dynamic, because individuals in these plans needing higher-level services that cannot be appropriately provided via telehealth will be especially likely to shift onto taxpayer-funded programs. Therefore, our organizations believe it is imperative that any new plan types must have to comply with the requirements of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act.

Finally, our organizations have concerns about shifting to telehealth-only (or telehealth-first) plans at a time when concerns have been raised about some platforms' business practices. There have been recent reports about some direct-to-consumer telehealth companies selling sensitive medical information to advertising platforms, which severely threatens patient privacy and trust in the medical community.[5] We urge the committee to work to address such abuses and to reconsider the unintended consequences of allowing telehealth as an excepted benefit until further protections are put in place to safeguard the health and privacy of individuals and their families.

Thank you for your consideration.

Sincerely,

Alsana

American Association on Health and Disability

American Counseling Association

American Psychological Association

American Society of Addiction Medicine

American Therapeutic Recreation Association

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[5] Feathers T, Palmer K, Fondrie-Teitler S. (December 22, 2022). "Out of Control": Dozens of Telehealth Startups Sent Sensitive Health Information to Big Tech Companies. *STAT News*. Retrieved from https://www.statnews.com/2022/12/13/telehealth-facebook-google-tracking-health-data/

Center for Discovery

Centerstone

Children and Adults with Attention-Deficit/Hyperactivity Disorder

Eating Disorders Coalition for Research, Policy, & Action

Eating Recovery Center

Global Alliance for Behavioral Health and Social Justice

International OCD Foundation

Lakeshore Foundation

Legal Action Center

Mental Health America

Monte Nido & Affiliates

National Alliance on Mental Illness

Network of Jewish Human Service Agencies

Pathlight Mood and Anxiety Center

Prosperity Eating Disorders and Wellness

REDC Consortium

RI International

The Kennedy Forum

The Renfrew Center for Eating Disorders

National Alliance on Mental Illness

June 20, 2023

Hon. Brett Guthrie
Chairman
Subcommittee on Health
House Energy and Commerce Committee

Hon. Anna Eshoo
Ranking Member
Subcommittee on Health
House Energy and Commerce Committee

Dear Chairman Guthrie and Ranking Member Eshoo,

We would like to express our gratitude to you for considering the *Re-entry Act* (H.R. 2400) and the *Due Process Continuity of Care Act* (H.R. 3074) as part of your hearing on solutions to address substance use disorders. These two pieces of legislation are central to any effort to address the mental health and substance use crisis our country is facing. We strongly encourage you to support and advance these two bills.

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for people affected by mental illness. We support the elimination of the Medicaid Inmate Exclusion Policy (MIEP), which prohibits the use of federal funds for medical care provided to inmates of a public institution – disconnecting people from vital care as they transition between incarceration and community. This outdated policy no longer works for our communities and contributes to recidivism and poor health outcomes for those who become involved in the criminal justice system.

This is particularly important to NAMI because, according to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental health condition.

The *Re-entry Act* would allow incarcerated individuals to receive services covered by Medicaid 30-days prior to their release from jail or prison and, the *Due Process Continuity of Care Act* would require states to continue Medicaid coverage for those who are incarcerated but awaiting trial. Passage of these vital pieces of legislation would take a necessary and important step toward improving health outcomes for incarcerated individuals, reducing recidivism, and providing people a better chance for success as they reenter their community. Both bills have broad bipartisan and bicameral support.

Thank you for your consideration and continued commitment to addressing the mental health and justice related needs of local communities. NAMI stands ready to answer any questions and looks forward to working with you.

Sincerely,

Hannah Wesolowski
Chief Advocacy Officer
NAMI, National Alliance on Mental Illness

CC: Hon. Cathy McMorris Rodgers (Chair); Hon. Frank Pallone (Ranking Member); Hon. Larry Bucshon; Hon. John Sarbanes; Hon. Michael Burgess; Hon. Tony Cárdenas; Hon. Bob Latta; Hon. Raul Ruiz; Hon. Morgan Griffith; Hon. Debbie Dingell; Hon. Gus Bilirakis; Hon. Ann Kuster; Hon. Bill Johnson; Hon. Robin Kelly; Hon. Richard Hudson; Hon. Nanette Barragán; Hon Buddy Carter; Hon. Lisa Blunt Rochester; Hon. Neal Dunn, M.D.; Hon. Angie Craig; Hon. Greg Pence; Hon. Kim Schrier; Hon. Dan Crenshaw; Hon. Lori Trahan; Hon. John Joyce; Hon. Diana Harshbarger; Hon. Mariannette Miller-Meeks; Hon. Jay Obernolte

June 21, 2023

The Honorable Cathy McMorris Rodgers
Chairwoman
Committee on Energy & Commerce
U.S. House of Representatives
2188 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy & Commerce
U.S. House of Representatives
2107 Rayburn House Office Building
Washington, DC 20515

**Re: Patient community concerns about the detrimental impact of HR 824, the Telehealth Benefit Expansion for Workers Act**

Dear Chairwoman McMorris Rodgers and Ranking Member Pallone,

The 23 undersigned organizations represent more than 120 million people living with a pre-existing condition in the US. Collectively, we have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that are critical components of any discussion aimed at improving or reforming our healthcare system.

Our organizations share three principles that we use to help guide our work on healthcare to continue to develop, improve upon, or defend the programs and services our communities need to live longer, healthier lives.[i] These principles state that healthcare must be adequate, affordable, and accessible.

With these principles at the forefront, we write to convey our concerns about HR 824, the Telehealth Benefit Expansion for Workers Act. In the report "Under-covered: How 'Insurance-Like' Products Are Leaving Patients Exposed," many of our organizations documented our concerns with health insurance products that are not required to comply with the patient protections enacted in the Affordable Care Act.[ii] We are concerned that policies included in the legislation considered today would decrease the number of consumers enrolled in comprehensive health insurance plans and threaten access to quality, affordable healthcare for the patients and consumers we represent.

Telehealth has long been a vital care delivery method for improving access in underserved communities, particularly rural areas, areas with physician shortages, and areas with limited access to primary care services. However, the COVID-19 pandemic has highlighted the role of telehealth in helping patients continue to receive timely and safe healthcare services and treatments from their providers. Telehealth – including telemedicine and telemental health – can help reduce gaps in access to services and care, including access to primary care and specialized providers, when in-person visits are not a safe or feasible option. Today, nothing prevents an employer or health insurance carrier from offering telehealth coverage in conjunction with their health coverage, and many do.

Telehealth can and should be used to increase patient access to care and our organizations have issued principles to aid lawmakers in setting appropriate policies to achieve that goal.[iii]

We are concerned that HR 824 would create a new excepted benefit for telehealth services. Excepted benefits are a category of coverage exempt from most federal and state standards that apply to health insurance. This means that a telehealth excepted benefit could discriminate against patients with a pre-existing condition by refusing to cover certain treatments, charging more for coverage, or denying coverage altogether.

Excepted benefits coverage can take many forms, including disease-specific policies like cancer-only, dental, and fixed indemnity plans. These plans are designed to supplement a major medical insurance plan. They are *not* comprehensive coverage and, in many cases, they are not allowed to coordinate with other coverage. These products are often exempted from federal regulation and primary regulation authority lies at the state level. While telehealth is an important coverage, it is insufficient on its own without major medical health insurance.

During the COVID-19 public health emergency, the federal government temporarily allowed employers to offer stand-alone telehealth benefits as a means to give individuals not eligible for their employer plan access to at least some care at a time when many patients and providers were worried about the health risk of in-person care. However, employers were not allowed to offer the stand-alone telehealth benefit to individuals who could enroll in their employer plan, nor did the guidance exempt these stand-alone benefits from all consumer protections.

HR 824 would go well beyond that guidance: Employers would be able to offer the stand-alone benefit as an alternative to their comprehensive plan. Low-wage workers, in particular, would be at risk of enrolling in the lower-cost telehealth plan, thinking it will provide comprehensive coverage when it won't.

Even in the best-case scenario, where an individual enrolls in a comprehensive employer plan and the telehealth-only policy, we are concerned that a telehealth-only policy could create significant frustration and confusion for consumers who need in-person care to diagnose and treat their symptoms. Consider

the scenario of a patient who sees a provider via telehealth and then in person, as many do in the course of receiving a diagnosis and treatment. Then imagine navigating two separate insurance companies to receive that care – two sets of paperwork, two sets of prior authorization, two sets of network limitations, two sets of cost-sharing responsibilities, and so on. Not to mention the telehealth provider and in-person provider may be two different providers within two different medical systems. As a result, the telehealth provider would not necessarily have access to the patient's medical history and thus would be hampered in their ability to adequately treat and diagnose the patient.

Lastly, we want to draw the committee's attention to a concerning trend. In recent years, excepted benefits have been marketed and sold – sometimes bundled – as replacements for traditional health insurance.[iv] This can lead to significant consumer confusion and a false sense of security for people who believe they've purchased high-quality coverage, only to find substantial gaps and higher out-of-pocket costs when they use their plan. And as we have seen with other types of non-ACA compliant coverage, disclosures alone are not adequate to protect against these risks.

In sum, we are concerned that HR 824 would be harmful to patients and consumers, and we encourage the Committee to instead consider approaches that would promote consumer access to integrated telehealth benefits within a comprehensive health plan. If you have questions or would like to discuss this further, please contact Brian Connell VP, Federal Affairs with The Leukemia & Lymphoma Society at brian.connell@lls.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Asthma and Allergy Foundation of America
CancerCare
Child Neurology Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Muscular Dystrophy Association
National Eczema Association
National Health Council
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society

[i] Consensus Healthcare Reform Principles. https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/PPC-Coalition-Principles-FINAL.pdf.

[ii] Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed. https://www.lls.org/advocate/under-covered-how-insurance-products-are-leaving-patients-exposed.

[iii] Principles for Telehealth Policy. https://www.lung.org/getmedia/ac136df2-5984-46b6-9503-8523f71f5425/FINAL-Principles-for-Telehealth-Policy-_8_27_2020-(003).pdf.

[iv] Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk. https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk.

Anoka County
BOARD OF COMMISSIONERS
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June 20, 2023

MATT LOOK
Chair, District #1

The Honorable Brett Guthrie
Chairman
House Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
House Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Chairman
House Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20505

Dear Chairman Rodgers, Chairman Guthrie, Ranking Member Pallone, and Eshoo:

On behalf of our County Commissioners, we appreciate you holding today's hearing on *Responding to America's Overdose Crisis: An Examination of Legislation to Build Upon the SUPPORT Act.* This legislation is critical to ensuring we find a solution to the unnecessary deaths occurring in this country due to drug overdoses.

This hearing is also important because I hope there is an opportunity to discuss H.R. 3074, the *Due Process and Continuity of Care Act*, introduced by Rep. Trone and a bipartisan group of lawmakers. A large percentage of people awaiting trial today have drug addictions, and correcting a flaw in our judicial system is key to ensuring these people get the continuity of care they need.

*We hope you will consider this legislation and support including it in a larger healthcare/mental health package that comes before this Committee and the full House this year.*

H.R. 3074 is critical to those awaiting trial, their families, and the community at large. Our judicial system is built around the premise that people are presumed innocent until proven guilty. Today that is not the case for those on Medicaid awaiting trial. Under current law, a person loses their federal benefits, like Medicaid, when they are incarcerated and awaiting trial. This standard does not apply to others detained and accused of a crime. Those not receiving federal support do not lose their due process rights while they await trial. The same standards should apply to all and not some. H.R. 3074 corrects a flaw in our justice system.

This is more than a due process of rights issue. This is a mental health issue facing our country. Today pretrial detainees have substantially higher rates of mental health conditions and substance use disorders than the general population – roughly 44% of all pretrial detainees have a mental health condition, and 63% have a substance use disorder.

Since many mental health conditions and all substance use disorders are chronic, a sudden absence of stabilizing treatment exacerbates these health problems and requires more intensive and costly care later, contributing to re-arrest and increased recidivism. Furthermore, federal health benefits are rarely immediately restored upon release as the re-enrollment process can be lengthy, often taking upwards of 90 days, which frequently leads to returning to illicit drug use without stabilizing care. Therefore, ensuring continued access to federal health benefits will improve healthcare for pretrial detainees and help break the cycle of recidivism caused by untreated mental health conditions and substance use disorder.

The Due Process Continuity of Care Act would address this issue by amending the MIEP to allow states to decide whether to ensure pretrial detainees do not lose Medicaid coverage of health care services. Last year, a piece of this bill applying to juveniles was included as part of the FY23 omnibus, but it remains vital to ensure that all pretrial adults do not lose their Medicaid coverage before they are adjudicated.

The cost of not acting is too high. The budgetary costs will be more than double the cost of this bill. The potential loss of life due to a person not getting the care they need will be too high a price to pay for those who may take their own life or hurt someone in the community because they are not getting the care and medication they need to be productive citizens in the community.

Chairman McMorris-Rodgers and Ranking Member Pallone, we urge you and the Committee to support this legislation. We cannot have laws that work for some and not others. We cannot put people at risk thinking we are saving money. Those receiving these benefits need your help. Our community is at greater risk if these individuals are denied access to the care they need. This bill saves money and lives.

Thank you for considering this critical issue facing every county across the country. If you or your team have any questions, please have them contact me at 612-558-9111.

Respectfully,

Matt Look, Chair
Anoka County Commissioner