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**Statement for the Record
Committee on Energy and Commerce
Subcommittee on Health**

Combating the Opioid Crisis: Prevention and Public Health Solutions
March 21-22, 2018

Thank you for your work regarding the nation's opioid crisis. America's Essential Hospitals appreciates your committee's dedication in its response to this public health threat, which affects all communities nationwide. Below, we outline the unique role essential hospitals play in addressing the opioid crisis, share issues that impact our hospitals, and comment on several bills before your committee.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to providing high-quality care to all people. Filling a vital role in their communities, our 325 member hospitals provide a disproportionate share of the nation's uncompensated care and devote about half their inpatient and outpatient care to Medicaid or uninsured patients. Through their integrated health systems, members of America's Essential Hospitals offer primary care through quaternary care, including trauma care, outpatient care in ambulatory clinics, public health services, mental health and substance abuse services, and wraparound services vital to disadvantaged patients. More than a third of patients at essential hospitals are racial or ethnic minorities who rely on the culturally and linguistically competent care that only our members can provide.

As pillars of their communities and trusted providers for all, essential hospitals have seen firsthand how opioid use disorders have affected individuals and their surrounding communities. Essential hospitals lead in efforts to improve population health and continue to develop innovative programs to prevent opioid misuse among the most vulnerable populations, and they provide treatment to all who need it. As you continue to develop policies to combat the crisis, we urge the committee to consider the unique role essential hospitals play in prevention of opioid misuse, as well as response and recovery for individuals struggling with opioid use disorders.

Essential Hospitals Response to Opioid Crisis

Essential hospitals play a unique and significant role in the opioid crisis. Hospitals are a main care provider for people experiencing opioid-related health problems, like infection or overdose, associated with substance misuse. As a result, hospitals have an enormous role to play in the prevention and treatment of this widespread problem. Essential hospitals have partnered with pharmacies, public health departments, law enforcement, emergency medical services, and other community providers to combat the crisis.

For example, an essential hospital in Massachusetts has been a national leader in fighting the opioid crisis. The hospital runs the largest primary care office-based opioid treatment program in New England. The program was the first of its kind in the nation and has been replicated in

35 states. It employs a collaborative care model using nurse care managers to provide medication-assisted treatment (MAT) to individuals with opioid use disorder. The program has been tailored to meet the needs of other patient populations, including adolescents and pregnant women. In addition, this hospital created one of the first emergency department (ED)– and urgent care–based opioid treatment programs in the country, and its inpatient addiction consult service has reduced ED visits for participants by 30 percent. In partnership with the state health department, the hospital has pioneered naloxone distribution programs with law enforcement and other first responders and overdose bystanders.¹

Evidence-based treatment programs, which can exist within or outside a hospital system, are a key component of combating opioid use. One of the most commonly used treatment models—MAT—uses counseling in combination with drugs, such as methadone and buprenorphine, to prevent withdrawal, suppress cravings, and support recovery. MAT has proved successful in decreasing mortality, decreasing risk of infection, improving social functioning, and increasing retention in rehabilitation programs. But there are large gaps between MAT capacity and demand. To meet this need, some health systems are developing their own infrastructure and care teams—which include physicians, licensed therapists, counselors, and/or recovery specialists—to treat opioid misuse.² Essential hospitals are deploying protocols that screen for opioid use, provide MAT as necessary, and pair patients with addiction counselors.

Additionally, essential hospitals are deploying targeted improvement efforts to address opioid prescribing patterns and align incentives that promote quality of care. For example, several essential hospitals have implemented new guidelines for prescribing opioids, particularly in the ED. These hospitals urge providers to first provide non-opioid options—ibuprofen and acetaminophen, for example—and then to explore alternative pain management, such as localized nerve-blocking methods. Hospitals engage physicians, pharmacists, and nurses to ensure all staff are committed to providing non-opioid regimens before prescribing stronger medications. Initial evaluations show that such policies reduced by nearly 50 percent the number of opioids prescribed to trauma patients.³

Essential Hospitals Face Challenges

42 CFR Part 2

Although essential hospitals have deployed innovative approaches to treat patients with opioid and substance use disorders, they continue to face challenges. When patients visit doctors and hospitals, most assume providers have a complete medical history and an awareness of addictions or substance use that need to be factored into treatment and prescribing. But that is not always the case, due to an antiquated regulation—42 CFR Part 2 (Part 2).⁴ This regulation limits access to and use of patients’ substance use records for certain substance use treatment programs. Obtaining multiple consents from the patient is challenging and creates barriers to whole-person, integrated approaches to care. As a result, many providers often learn of addiction problems only after an adverse event or an overdose. Part 2 regulations also might lead to a physician treating a patient and writing prescriptions for opioid pain medication for that individual without knowing the person has a substance use disorder. Separation of a patient’s addiction record from the rest of that person’s medical record creates several problems and

¹ Susman K. *The Opioid Crisis: Hospital Prevention and Response*. June 2017. <https://essentialhospitals.org/wp-content/uploads/2017/06/Opioid-Brief-1.pdf>. Accessed March 19, 2018.

² Ibid.

³ Susman K. *The Opioid Crisis: Hospital Prevention and Response*. June 2017. <https://essentialhospitals.org/wp-content/uploads/2017/06/Opioid-Brief-1.pdf>. Accessed March 19, 2018.

⁴ 42 U.S. Code § 290dd–2.

impedes patients' ability to receive safe, effective, high-quality substance use treatment and coordinated care.

It is crucial that Part 2 is better aligned with the Health Insurance Portability and Accountability Act (HIPAA) so that health care providers can provide comprehensive and coordinated substance use treatment and care. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently released a final rule that takes some steps to modernize Part 2, but it does not go far enough.⁵ Lawmakers must act to modify Part 2 and bring substance use records into the 21st century, allowing for appropriate levels of access for providers to have a complete picture of their patients. However, just aligning Part 2 for treatment purposes is an insufficient approach. Such an approach is inconsistent with HIPAA language on treatment, payment and health care operations, as care coordination activities are not considered a part of a patient's treatment. For Medicaid providers engaging in whole-person care management, it is difficult to separate treatment from payment and health care operations. Also, only aligning Part 2 with HIPAA for treatment activities could preclude a robust prescription drug monitoring program. Without all information about a patient available, it will be challenging to flag patients engaging in drug-seeking behaviors.

IMD Exclusion

Medicaid does not provide reimbursement for inpatient treatment in an institution for mental disease (IMD) with more than 16 beds. As states consider various approaches to combat the opioid crisis, this IMD exclusion has hampered comprehensive treatment approaches. The Centers for Medicare & Medicaid Services (CMS) has encouraged states to pursue innovations and strategies to address the opioid epidemic through Medicaid Section 1115 waiver demonstrations. In a November 2017 update to states, CMS outlined a streamlined approach to accelerate states' ability to respond to the crisis.⁶ Several states, such as West Virginia, Maryland, and Virginia, have used this approach to start comprehensive, evidence-based prevention and treatment programs for Medicaid beneficiaries.

Additional Challenges

The Medicaid program covers MAT services as an optional benefit for states under the Medicaid statute, which has caused available services to vary widely across states.⁷ This limits providers as they identify and employ the best treatment options for their patients

Essential hospitals also face the additional challenge of a workforce shortage for substance use disorder and behavioral health professionals. There has been a shortage of addiction specialists for decades, and the opioid epidemic only has increased demand.⁸ SAMHSA recognized the serious workforce shortages for behavioral health professionals and funded several programs and initiatives to combat the issue. Essential hospitals operate on slim margins that might hinder them from offering competitive compensation packages to attract needed substance use disorder and behavioral health professionals. Not only do they have financial constraints, many essential hospitals find themselves either in extremely competitive urban markets or in less desirable geographic areas.

⁵ 82 *Federal Register* 6052. January 18, 2017.

⁶ Centers for Medicare & Medicaid Services. *SMD #17-003 Strategies to Address the Opioid Epidemic*. November 1, 2017. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. Accessed March 19, 2018.

⁷ Medicaid and CHIP Payment and Access Commission. *Medicaid and the Opioid Epidemic*. June 2017. <https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf>. Accessed March 19, 2018.

⁸ Corwin E. *Shortage of Addiction Counselors Further Strained by Opioid Epidemic*. February 24, 2016.

Last, essential hospitals lack adequate reimbursement for integrated care. Overall care delivery is transforming across the health care industry, shifting from fragmentation and care siloes to a more integrated and collaborative system. In responding to the opioid crisis, essential hospitals recognize the complexity and importance of treating behavioral health issues, particularly as they relate to improving care for our nation's most vulnerable patients. Essential hospitals across the United States have dedicated substantial resources to developing innovative programs to improve care coordination among primary care, inpatient, behavioral health, and community-based services for individuals with behavioral health disorders. For example, an essential hospital in Washington state began a behavioral health integration program that incorporates behavioral health care managers and psychiatric consultants at 14 primary care clinics.⁹ Primary care physicians in the clinics conduct routine screening for behavioral health disorders among patients, determine whether further assessment and diagnosis by behavioral health specialists is required, and, when necessary, provide warm handoffs to care coordinators within the same facility. As providers of care to vulnerable populations, essential hospitals are uniquely positioned to implement this kind of care. But funding shortfalls and reimbursement structures pose consistent and significant obstacles to integration.

Legislative Proposals

Prescription Drug Monitoring Programs and H.R. ____, to enhance and improve state-run prescription drug monitoring programs,

Prescription drug monitoring programs (PDMPs) are state-level interventions to improve opioid prescribing and inform clinical practice by tracking the prescribing and dispensing of controlled prescription drugs. Some states have implemented policies that require physicians to check a state PDMP to assess a patient's risk of substance use disorders or nonmedical use of controlled substances as part of the discharge planning and medication reconciliation process. The legislative proposal before the committee would seek to improve PDMPs by authorizing the Centers for Disease Control and Prevention to conduct certain surveillance activities to improve data collection and integration in physician clinical workflow.

We support the goal of reducing prescription drug abuse by increasing provider awareness of at-risk patients. However, the challenges associated with PDMPs—including issues with health IT interoperability, timely data transmission, and privacy and security—make this tool an unsatisfactory option for now. Further, the quality of PDMP data must be validated before its use in the context of a federal program, such as Medicaid. For example, PDMPs do not include data on physician specialty or patient diagnosis, which can make it difficult to distinguish legitimate use, such as higher doses for cancer pain management, from inappropriate use, such as use in pediatrics. Additionally, platforms differ by state, creating a lack of uniformity in accessing PDMP data. More work is needed to mitigate issues of cross-state PDMP data access—e.g., allow prescribers and dispensers to obtain patients' prescription records from across state lines to provide a more complete in-state and out-of-state medication history for at-risk patients. Continued state-level evaluation of PDMPs is needed to identify and evaluate promising practices and to build synergies necessary for application at the federal level. We hope the committee will consider these concerns.

H.R. 5197, Alternatives to Opioids in the Emergency Department Act

⁹ Rangarao S, Susman K. *Behavioral Health and Primary Care Integration at Essential Hospitals*. October 2015. http://essentialhospitals.org/wp-content/uploads/2015/10/BehavioralHealthBrief_FINAL.pdf. Accessed March 19, 2018.

We support legislation that would encourage alternatives for opioid use in hospital EDs. Specifically, we are encouraged by consideration of H.R. 5197, the Alternatives to Opioids (ALTO) in the Emergency Department Act. This legislation would allow hospitals to rein in opioid prescribing by assessing the use of alternate medication options for pain management. This protocol is currently underway at St. Joseph's Health, an essential hospital in Paterson, New Jersey, and is an effective tool to combat opioid addiction.

H.R. 5102, Substance Use Disorder Workforce Loan Repayment Act

Health care workforce shortages present significant challenges. Substance use disorder (SUD) treatment professionals are critical in the fight against opioid addiction, and creating incentives for health care and other social service professionals to treat individuals with SUDs will help to strengthen the workforce in an area with severe needs. Given the financial burden often placed on students training in health-related fields, H.R. 5102, the Substance Use Disorder Workforce Loan Repayment Act, will take a step in the right direction to encourage health professionals to work directly on SUD treatment. By offering student loan repayment for these professionals, essential hospitals, who often treat some of the most significant opioid addiction cases, will have greater access to trained SUD professionals and can expand their work already underway to fight opioid addiction.

H.R. 5261, Treatment, Education, and Community Help to Combat Addiction Act

America's Essential Hospitals supports H.R. 5261, the Treatment, Education, and Community Help to Combat Addiction Act, which would support learning institutions that specialize in SUD treatment education to improve how health professionals are taught about SUD and pain management for patients. This bill would help address gaps in educational programs provided to physicians at essential hospitals to ensure SUD patients receive the most comprehensive care for their exposure to opioids.

H.R. ___, Poison Center Network Enhancement Act

The Poison Center Network Enhancement Act would reauthorize the national network of poison control centers, which offer free, confidential, expert medical advice and serve as primary resources for poisoning information. Essential hospitals frequently work in tandem with poison control centers to address public health emergencies, including opioid exposures. Specifically, these centers help lessen the burden on EDs through in-home treatment for opioid exposures. Reauthorizing this network would allow for broader communication between the centers to improve care for those exposed to opioids before they enter hospital systems.

Discussion Draft of H.R. ___, A Bill to Support the Peer Support Specialist Workforce

We support including language to improve the peer support specialist workforce. This provision would expand Department of Health and Human Services grants to peer support specialist organizations providing recovery services. Peer support specialists are individuals recovering from a substance use disorder (SUD) who have received formal training on how to support and mentor other individuals new to the recovery process. Peer support has been a successful tool to support individuals newly diagnosed with a disease or disorder. Essential hospitals have successfully used multidisciplinary approaches to the treatment of individuals with SUDs, and peer support specialists can be a critical tool to an individuals' recovery.

We appreciate your consideration of these provisions and look forward to working with you to improve the legislative package to effectively counter this ongoing crisis.

