



Charles N. Kahn III  
President and CEO

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

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

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

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

Dear Chairmen Brady and Roskam and Ranking Members Neal and Levin,

Thank you for your letter inquiring about steps that can be taken to address our nation's opioid crisis. As you note in your letter, the rate of increase in deaths resulting from opioid-related drug overdoses is staggering. It is alarming that opioid overdoses fall within the top 10 leading causes of death in the United States. Unfortunately, overdose deaths related to opioid analgesics increased more than threefold from 1999 and 2011 and overdose deaths related to heroin more than tripled in just 3 years from 2011 to 2014. This crisis has taken too many American lives and has touched countless more American families. We appreciate the opportunity to offer our insight on the role hospitals are playing in meeting the challenges of the crisis and on what additional tools and policies are likely to be helpful in both preventing and treating opioid addiction and the acute and long-term medical needs that stem from their misuse.

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. FAH member hospitals see and care for patients throughout the continuum of

care required for opioid addiction and treatment. Whether it is acute care treatment provided in an emergency department or inpatient behavioral health treatment provided over a longer course of time, FAH hospitals are providing the care and resources needed by our patients to address the consequences and causes of opioid addiction.

### **Hospitals are On the Front Lines of the Crisis and are Responding**

According to new data released by the Centers for Disease Control and Prevention (CDC), emergency department visits for opioid overdoses rose 30% across the United States from July 2016 to September 2017. Such an acute rise in patient volume stretches the physical capacity to treat these patients and also requires hospitals to prepare to treat, in larger numbers, patients presenting with opioid overdose related symptoms. Beyond emergency treatment, hospitals are playing a critical role in coordinating the acute care required through referral to or direct treatment of the underlying substance use disorder (SUD).

Prescription opioids are used in both the inpatient and outpatient settings as part of a pain management regimen. However, their addictive power cannot be ignored or underestimated. As such, hospitals continue to update the protocols for their use based on the latest clinical evidence and have taken steps to ensure they are not diverted for illicit use.

Most importantly, our hospitals are working hard to study and develop alternative approaches to treating pain, explore the appropriateness and effectiveness of these approaches, and design and implement changes throughout the hospital that reduce the dependency on prescription opioids. We are working in collaboration with our physicians, pharmacists, and nurses to review the clinical evidence and best practices that can help our patients effectively manage pain through alternative treatments.

Beyond this clinical work, hospitals are joining with their communities to help address the crisis. Partnerships with health departments, other providers, and community organizations are proving beneficial in understanding the extent of the crisis, providing targeted resources, and extending education to providers.

There is, of course, far more to do, and there are a number of policies that we believe could have a measurable impact on addressing the crisis.

### **Health Insurance Coverage Fundamental to Addressing Crisis**

Eligibility for and enrollment in health insurance, including Medicaid, is key to providing access to critical SUD treatment and vital hospital services. According to data from the Healthcare Cost and Utilization Project at the Agency for Healthcare Research and Quality (AHRQ), the uninsured rate for opioid-related hospitalizations in Medicaid expansion states has decreased dramatically. In these same Medicaid expansion states, individuals with SUD diagnosis have improved access to mental health care and primary and preventive care. Sustaining and growing the gains in health insurance coverage is essential to connecting those in need with critical services.

While health insurance coverage is critical, it is also important that the coverage offer the types of benefits needed to access appropriate care. To that end, it is important that the Essential Health Benefits requirements remain in place and cover benefits for addiction treatment; that mental health parity requirements are enforced; and that we continue to promote the integration of SUD treatment and other forms of health care.

Additionally, Medicaid currently prohibits, in most instances, federal Medicaid funding to be used to reimburse for inpatient care provided in an Institution for Mental Disease (IMD) with more than sixteen beds. While under current Medicaid managed care rules, at state direction, federal funds can be used to reimburse for short-stays (15 days or less per month) by a Medicaid beneficiary in an IMD, more should and can be done to make these services available. As one of the needs in addressing the crisis is expanded capacity for acute, inpatient psychiatric and substance use disorder services, current Medicaid restrictions should be removed so that IMDs can be a greater part of addressing the crisis. By expanding the use of services provided in an IMD, we can help assure that the availability of the appropriate resources meets the national need.

### **Expanded Data Sharing Among Prescription Drug Monitoring Programs (PDMPs) Needed**

The FAH supports the Committee's efforts in expanding data sharing among PDMPs, including with the Centers for Medicare & Medicaid Services (CMS) and other health care entities.

PDMPs play a critical role in combating the opioid epidemic. PDMPs add accuracy to providers' clinical judgements when they need to determine the requirements for pain management. PDMP's also make it possible to distinguish prescription shoppers from persons with genuine medical need. Finally, PDMP's have the data necessary to identify fraudulent prescribing or outliers in the prescribing of controlled substances. However, PDMPs are not updated real-time and often include varying levels of information. Consistent, real-time, standardized PDMP's, accessible to health systems in addition to providers or pharmacists, can lead to increased monitoring and reporting that effects changes in opioid-related outcomes such as opioid prescribing behavior, opioid diversion and supply, opioid misuse, and opioid-related morbidity and mortality.

The potential barriers to an effective implementation of expanded data sharing and its utility are many. These may arise from: 1) lack of provider awareness of PDMP laws or regulations, 2) technical barriers (e.g., issues with registration, data access difficulties at the provider level) and absence of both interoperability and standardization among state PDMPs, and 3) data issues due to omission resulting from non-compliance in reporting or data errors. We urge the Committee to pursue solutions to these challenges in the following ways: 1) engage states in identifying barriers and solutions for increased PDMP utilization and data completeness, 2) develop standards among PDMPs, pharmacy software vendors, and electronic health records (EHRs) to sustain interoperability across systems, 3) strongly encourage and facilitate the submission of timely and accurate data from dispensers by facilitating seamless access and integration of PDMPs into EHRs, and 4) identify ways to support state level data collection and sustainability of PDMPs. These solutions should be concurrently mindful of unintended

consequences such as reporting burden and provider perceptions of legal risk leading to inadequate pain control of patients or alternate medication substitution effects.

### **Medication Assisted Treatment (MAT) Important**

MAT for opioid use disorder reduces opioid-related morbidity and mortality, prevents relapse, and decreases illegal opioid use. Broader integration of MAT in the primary care setting in conjunction with increases in the number of SUD treatment facilities expands access to treatment and reduces stigma. Recent legislation has vastly increased coverage of SUD treatment in primary care, raising the importance of identifying best practices.

An AHRQ-commissioned study recently identified 4 key components of MAT models in primary care: pharmacotherapy with buprenorphine or naltrexone, provider and community educational interventions, coordination and integration of opioid use disorder (OUD) treatment with other medical and psychological needs, and psychosocial services. Among successful programs identified through a systematic review, similar key design factors include: integrated clinical teams with advanced practice clinicians serving as clinical care managers, the use of patient “agreements” for accountability, and the use of home inductions to facilitate treatment for patients. Integrating advanced practice clinicians will increase patient access to treatment in particular among rural communities. Collaborative care interventions, based on the principles of the chronic care model, have also been shown to improve opioid-related outcomes. These are some of the examples that can be identified as best practices to promote coordinated and managed care.

### **Telehealth Offers Pathway to Services**

Health care services provided via telehealth are becoming more important to the health care delivery system and can play an important role in treating substance use disorder. By breaking down barriers to treatment (e.g., distance), telehealth can assist in connecting patients to qualified providers. Given the breadth of the crisis, it is important that we use all available pathways to treatment.

For example, MAT requires access to methadone or buprenorphine delivered in an observed dosing model by a licensed provider. The use of telemedicine in the delivery of opioid agonist or partial opioid agonist therapy has been demonstrated to be an effective alternative to in-person treatment with similar opioid-related outcomes where access to qualified providers is limited.

### **Allow Treating Providers to Access Their Patients’ Substance Use Disorder Records**

The Committee should consider steps needed to align the 42 CFR Part 2 requirements with the Health Insurance Portability and Accountability Act (HIPAA) requirements to allow the use and disclosure of SUD records from a federally assisted program for “treatment, payment, and health care operations” without prior written authorization. Currently, 42 CFR Part 2 requires individual patient consent to share addiction records from federally funded substance use treatment programs. Using the HIPAA requirements would improve patient care by enabling providers with a patient relationship to access their patient’s entire medical record.

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Thank you for the opportunity to provide our thoughts on such a critically important issue. We look forward to working with the Committee in the future. Should you have any questions regarding our comments, please feel free to reach us at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. ...". The signature is fluid and cursive, with a large initial letter and a long, sweeping tail.