National Alliance on Mental Illness

February 17, 2018

The Honorable Orrin G. Hatch
U.S. Senate
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, D.C. 20510

Submitted electronically via opioids@finance.senate.gov

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the National Alliance on Mental Illness (NAMI), I am pleased to submit the following comments on the bipartisan request to stakeholders for policy recommendations to address the opioid crisis in the United States. NAMI is the nation's largest organization representing people living with mental illness and their families. The current opioid crisis in our country disproportionately impacts people with mental illness and their families. Across the lifespan – from youth and young adults to adults and older adults – people with mental health conditions are at significantly elevated risk of opioid abuse relative to the general population. In fact, the Substance Abuse and Mental Health Services Administration (SAMHSA) has noted that 51% of opioid prescriptions are written for people with mental illness.

According to SAMHSA, among the 20.2 million adults in the U.S. who experienced a substance use disorder in a given year, 50.5%—10.2 million adults—had a co-occurring mental illness. Unfortunately, siloed treatment systems result in inadequate treatment and costly adverse outcomes, including addiction relapse, exacerbation of psychiatric symptoms and elevated risk of acute episodes or mania, depression and psychosis, as well as chronic and acute physical health conditions. A recent CMS letter to State Medicaid Directors on strategies to address the opioid epidemic states that "Medicaid beneficiaries who struggle with addiction to opioids or other substances have high rates of comorbid physical and mental health conditions, resulting in higher spending for general medical services. Recent research has reaffirmed that most spending on individuals struggling with addiction is not on treatment for those conditions, but instead focused on co-morbid physical conditions."

Co-morbid Substance Use and Opioid Disorders, Mental Illness and Chronic Health Conditions and the Cost Burden on Medicare & Medicaid

Treating opioid abuse poses a significant cost to both Medicare and Medicaid. The total Medicare costs associated with opioid use, misuse and overdoses are an estimated $6.4 billion. Notably, Medicare is the largest single payer for opioid overdose hospitalizations, which have increased by $73 per hospitalization per year since 2000.

Between 2010 and 2013, 75 percent of spending for adult Medicaid beneficiaries with a behavioral health disorder was for treatment of co-morbid conditions, as opposed to their behavioral health conditions. Research has shown that people with mental illness have 10-20 years of lower life expectancy relative to the general population in the US. This starkly higher mortality is driven largely by a higher prevalence of treatable co-morbid chronic medical conditions, such as cardiovascular disorders.

Among people with substance use disorders, co-morbid depression, bipolar disorder, post-traumatic stress disorder, nicotine dependence, and sleep disorders are common. People who are hospitalized for a health condition who also have a substance use disorder are at an increased risk of rapid re-hospitalization after discharge and greater health care use and costs.

At least one state has found significant reductions in medical costs among Medicaid beneficiaries who accessed addiction treatment compared to those who did not. Integrating mental health and substance abuse treatment through co-location of services and "no wrong door" policies can produce better outcomes at lower costs. Given the significant co-morbidity of mental health and physical health conditions with OUD and other substance use disorders, NAMI puts a high priority on investment in financing and regulations that demonstrably support and incentivize effective models of integrated care.

With this as background, NAMI would like to respond to three of the questions posed in the Committee's solicitation:

Question #3: How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?

Tele-health

Technology can help bridge barriers related to lack of providers and time and transportation constraints—as well as the stigma of seeking care—by allowing beneficiaries to receive care when and where they need it. Unfortunately, outdated laws and regulations prevent providers from most effectively using technology to provide care. NAMI recommends that the Committee build on the efforts to remove barriers to use of telehealth that began earlier this month with passage of the Medicare Extenders provisions in the two-year bipartisan budget agreement (many of which were also in the Committee's bipartisan Chronic Care legislation). It is critical that this is done in a way that does not incent inappropriate utilization, but allows for reimbursement of appropriate services regardless of how they are delivered.

Peer Support Specialists

According to SAMHSA, more than half of U.S. counties lack any practicing behavioral health workers and 77 percent of counties report unmet behavioral health needs. Ancillary care providers can help support medical professionals in delivering effective, evidence-based services and supports. However, many ancillary care providers are not reimbursed by Medicare. The prime example of this is peer support specialists and peer recovery coaches, which have been shown to improve relationships with treatment providers, increase treatment adherence,

increase beneficiary satisfaction with the overall treatment experience, improve access to social supports and provide greater housing stability.

NAMI believes that peer support specialists should be integrated into care teams and reimbursed under Medicare, as they have been by state Medicaid programs across the nation. At least 36 states offer providers the opportunity to bill Medicaid for mental health peer support services. It is time Medicare align with other payers in recognizing the importance of peer support specialists and the services they provide.

Equitable Payment

Recent research has revealed that psychiatrists are paid less by commercial health plans than primary care physicians or medical specialists for services billed to the same codes. This payment disparity may be contributing to lack of access to behavioral health providers in our country. While this payment disparity was in commercial plans, NAMI recommends that both Medicaid and Medicare evaluate whether behavioral health professionals and ancillary behavioral health providers are being paid on par with other health care professionals and ancillary providers and, if disparities exist, take steps to ensure equitable payment.

Institutions for Mental Disease (IMD) Exclusion

Many people with severe OUD, SUD and serious mental illnesses need a more intensive level of treatment and support. To provide this, it is vital to lift the IMD exclusion to allow for Medicaid payment for relatively short-term, facility-based care. Modifying the IMD exclusion throughout Medicaid programs would be an important step in recognizing that there is a compelling need for options to treat people with the most serious and complex conditions whose needs cannot be met in typical outpatient or intensive outpatient settings.

Alternative Payment Models for Chronic Pain Management and Co-Occurring Disorders

NAMI would like to note that Medicaid has adopted innovative payment models to support best practices, such as the Collaborative Care Model. More alternative payment and financing models are needed in both Medicaid and Medicare that cover the cost of providing effective interventions, especially team-based models, that address complex needs, such as chronic pain. It is critical to recognize that chronic pain is deeply affecting the lives of many Americans, including our Veterans, and is often accompanied by trauma, mental illness, substance use disorders and chronic health conditions. Any solution to the opioid crisis must include innovative financing in Medicaid and Medicare for multi-disciplinary approaches that address chronic pain and co-occurring disorders. Further, it is important to collect data and evaluate innovative interventions to establish practice-based evidence for effective treatment models.

Electronic Health Records (EHRs) and Health Information Technology (HIT)

The Committee can also remove a significant barrier to evidence-based screening, assessment, and treatment of mental health and substance use conditions and better patient outcomes by advancing bipartisan legislation, authored by Senators Portman and Whitehouse (S 1732), that would authorize a CMMI health IT demonstration program for behavioral health providers. NAMI believes strongly that the availability and adoption of health information technology and EHRs and their use for coordinated care is a necessary and valuable component to the treatment of those affected by substance use disorders and mental health conditions.

Unfortunately, despite the high need among mental health and substance use providers, health IT infrastructure is often lacking within behavioral health care settings. At the Medicaid and CHIP Payment and Access Commission (MACPAC) January 25, 2018 meeting, Principal Analyst Erin McMullen remarked on the lack of EHR availability, stating, "community-based substance use treatment providers have not adopted EHRs at the same rate as the rest of the medical system." Participants noted that many of these providers continue to share information by paper, phone, or fax. The roundtable discussion attributed the slow adoption of EHR to a lack of financial incentives. Most substance use and mental health providers were not eligible for financial incentives under HITECH that the rest of the health care system was able to access. Federal financial supports are needed, as they were with medical providers, to allow providers to invest in adopting, training on and using EHRs in their practices.

Question #6: What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs (PDMPs)?

Electronic Health Records

Electronic health records and related connectivity services are increasingly how data is shared in health systems. Current payment models for substance use and mental health providers and behavioral health clinics, coupled with their ineligibility for HITECH financial incentives, have left the specialty behavioral health system with little support for needed EHR adoption. Incentives that promote adoption of and training in EHRs among behavioral health providers would promote needed data-sharing.

42 CFR Part 2

Perhaps the most imposing and challenging barrier to the sharing of critical data is the antiquated federal regulation known as 42 CFR Part 2. This regulation, developed in the early 1970s, governs the confidentiality of drug and alcohol treatment and prevention records and sets requirements limiting the use and disclosure of patients' substance use records.

42 CFR Part 2 requires obtaining multiple consents from each individual patient, which is extremely challenging and creates barriers to the whole-person, integrated approaches to care that are vital to a more effective and cost-efficient health care framework. 42 CFR Part 2 separates substance use treatment from the rest of medicine, which only increases stigma around substance use disorders and hinders patients from receiving safe, effective, high quality substance use treatment and integrated care. In addition, 42 CFR Part 2 frequently results in physicians writing prescriptions for opioid pain medication, sometimes with tragic results, for patients whom they are unaware have substance use or opioid use disorders.

In the past year, SAMHSA has issued two final rules on 42 CFR Part 2. Both rules make incremental steps to modernize Part 2, but they do not go far enough. Legislative action is necessary to appropriately modify Part 2 and bring substance use records into the 21st century. Aligning 42 CFR Part 2 requirements with those in HIPAA regulation that allow the use and disclosure of patient information for "treatment, payment and health care operations" (TPO) would improve patient care by ensuring that providers with a direct treatment relationship with a patient have access to his or her complete medical record. Without access to a complete

record, providers cannot properly treat the whole person and may, unknowingly, endanger a person's recovery and his or her life. Importantly, harmonization of Part 2 with HIPAA would also increase care coordination and integration of care.

No one wants patients to be made vulnerable to adverse life outcomes as a result of seeking treatment for a substance use disorder. As a result, NAMI supports provisions that preclude Part 2 information from being disclosed for non-treatment purposes to law enforcement, employers, landlords, divorce attorneys, or others who may seek to use substance use information against the patient. NAMI urges the Committee to support the Protecting Jessica Grubb's Legacy Act, S 1850, co-sponsored by your colleagues Senators Shelley Moore Capito and Joe Manchin, which would align 42 CFR Part 2 with HIPAA for the purposes of TPO and would strengthen protections against the use of substance use disorder records in criminal proceedings. We recommend inclusion of this legislation in your Committee's legislative efforts to address the opioid crisis.

Data Facilitators and Aggregators

NAMI notes that prescription drug monitoring programs (PDMPs) are crucial sources of data for providers and pharmacists alike. PDMPs could have a larger impact in combatting the opioid epidemic if challenges in the current system were addressed, including lack of interoperability among states and with other health IT and lack of real-time data and information that is user-friendly and part of the workflow for providers.

To address current challenges, NAMI supports standardizing information across programs with a data facilitator or aggregator. Utilizing the National Council for Prescription Drug Programs (NCPDP) standards – Telecom and SCRIPT, information transmitted in real-time through a provider's e-prescribing system and a pharmacy's prescription dispensing system can be standardized, aggregated and provided to PDMPs and other appropriate parties. That data can then be used in conjunction with an algorithm to alert the prescriber or dispenser if a patient presents a risk, such as from a possible drug interaction or of "doctor shopping" for opiates.

NAMI recommends implementing models like the successful Medicare TrOOP facilitator. By utilizing a facilitator in the middle of these types of transactions, PDMP information would be enhanced and allow prescribers and dispensers to have the complete, accurate, real-time information they need to make the most appropriate clinical decisions.

Question #7: What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

CMMI Models and EHRs

CMMI is currently considering a potential payment or service delivery model to improve health care quality and access, while lowering the cost of care for Medicare, Medicaid, or CHIP beneficiaries with substance use and mental health conditions. We believe this financing demonstration should include behavioral health information technology. We cannot hope to address the opioid crisis successfully without providing incentives for the adoption of health information technology within behavioral health settings.

Certified Community Behavioral Health Clinics (CCBHCs)
Lastly, one Medicaid innovation that is enhancing the quality and integration of care is the Certified Community Behavioral Health Clinic (CCBHC) demonstration. Early results show that the CCBHC model is allowing clinics to increase and enhance their behavioral health workforce and improve outcomes for consumers. This is one of the most promising and important innovations for improving behavioral health care at a time when our country is experiencing both an opioid epidemic and a crisis in mental health care. As such, NAMI believes greater federal support for the CCBHC model, with a goal of making it available in every community across the country, is vital to the goals of the Committee.

Thank you for this opportunity to provide comment to the Committee on this important issue.

Sincerely,

Angela Kimball
National Director, Advocacy & Public Policy