NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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Sen. Orrin Hatch, Chairman
Sen. Ron Wyden, Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

16 February 2018

Dear Chairman Hatch and Ranking Member Ron Wyden:

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

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

Background

Most substance use disorders (SUDs) go untreated. In 2016, 20.1 million individuals had an SUD and needed treatment; however, 89 percent of those individuals did not receive treatment.[1] This is referred to as the "treatment gap." Meanwhile, more than 63,000 people—roughly 174 people every day—died from a drug overdose in 2016, reflecting a 21-percent increase from 2015[2]. Two-thirds of these deaths involved an opioid and were largely driven by deaths due to heroin, which has increased 533 percent from 2002. Despite these statistics, only 19 percent of

[1] SAMHSA, Center for Behavioral Health Statistics and Quality. *2016 National Survey on Drug Use and Health, Detailed Tables, Table 5.50A* (September 2017), *2016 National Survey on Drug Use and Health, Detailed Tables, Table 5.50A*

[2] Hedegaard H, Warner M, Miniño AM. *Drug overdose deaths in the United States, 1999–2016.* NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017.

individuals with an opioid use disorder (OUD) received OUD treatment[3] and just 26 percent of individuals with a heroin use disorder received medication assisted treatment (MAT).

Reflecting this trend, opioid-related hospitalizations increased by 150 percent between 1993 and 2012.[4] Between 2005 and 2014, the national rate of opioid-related inpatient stays increased 64.1 percent and the national rate of opioid-related emergency department visits nearly doubled with an increase of 99.4 percent.[5] Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids.

The good news is recovery from SUDs is possible with effective treatment. However, the rates of recovery are significantly low because most patients do not access the treatment system. The treatment continuum includes a range of services that can effectively address the spectrum of individual needs, but most patients do not receive evidence-based care. And when they do receive care, they rarely receive a sufficient amount**.** Moreover, the range of treatment is not coordinated or used optimally and therefore falls short of managing symptom recurrence (known as "relapse") and sustaining long-term recovery.

These data show clearly that the fight against opioids needs help from the private sector to increase treatment capacity and care. We can begin to close the treatment gap through these steps:

- provide states relief from the antiquated Institutions for Mental Diseases (IMD) exclusion;
- repeal the Medicare 190-day lifetime limit on inpatient mental health care; and
- modify the recently announced $6 billion in federal funding for the opioid crisis to encourage states to pilot financing models for addiction care that are independent of traditional grants.

Medicaid Institutions for Mental Diseases (IMD) exclusion

Since 1965, the IMD exclusion has prohibited federal payments to states for services to adult Medicaid beneficiaries between the ages of 21 and 64 who are treated in facilities that have more than 16 beds, and that provide inpatient or residential behavioral health (substance use disorders and mental illness) treatment. Half of all inpatient and residential substance use disorder treatment facilities meet this definition, meaning that Medicaid will not pay for beneficiaries treated in 50 percent of substance use treatment facilities in the United States.[6]

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[3] WuL.-T. Wu et al. / *Treatment utilization among persons with opioid use disorder in the United States.* Drug and Alcohol Dependence 169 (2016) 117–127

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

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

[6] United States Government Accountability Office Report, *MEDICAID: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, August 2017: https://www.gao.gov/assets/690/686456.pdf

In recent decades, the IMD exclusion has contributed to the decrease in inpatient and residential treatment, siphoning critical capacity at a time when every treatment slot counts. From 1990 to 2008, the number of adult inpatient and residential behavioral health treatment beds decreased by 35 percent.[7]

This decline has had a negative effect on access: more than 26 percent of adults on Medicaid (between the ages of 22 and 64, the population that the IMD exclusion affects) with a behavioral health condition reported unmet need for treatment, while fewer than 20 percent with other insurance reported an unmet need.[8] Also, during and directly after the number of available beds declined (between 1999-2014), the number of drug overdose deaths in the United States nearly tripled. Compounding the problem is that this increase was highest among individuals between the ages of 25 and 54, an age bracket directly in the middle of the IMD exclusion.[9]

While NAPHS supports a full repeal of the IMD, which two federal commissions—one non-partisan and the other bipartisan—recommended in the last year, we understand it may be necessary to take interim steps before that happens. One such step is to modify the Medicaid managed care rule that the Centers for Medicare & Medicaid Services (CMS) made final in 2016. Therefore, we recommend the Senate Finance Committee:

- Change the managed care IMD rule's per-stay cap to 25 days from the current cap of 15 days per stay.
- Change the per-beneficiary cap to an average facility length-of-stay cap.

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

Medicare 190 Life-time Limit

Medicare beneficiaries are limited to only 190 days of inpatient care in a psychiatric hospital in their lifetimes. No other lifetime limits exist in Medicare for any other type of inpatient care. Eliminating the 190-day lifetime limit will equalize Medicare mental health coverage with private health insurance coverage, expand beneficiary choice, increase access for the most seriously ill, improve continuity of care, and create a more cost-effective Medicare

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[7] Ibid

[8] Ibid

[9] Rudd, R.A, P. Seth, F. David, and L. Scholl. 2016. *Increases in drug and opioid-involved overdose deaths—United States, 2010–2015*. Morbidity and Mortality Weekly Report 65, no. 51: 1445–1452. https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm655051e1.pdf.

program. NAPHS has endorsed Rep. Paul Tonko's (D-N.Y.) *Medicare Mental Health Inpatient Equity Act* (H.R.2509) that would repeal the 190-day lifetime limit, and the Finance committee should pass it.

Grant Modification to Support Treatment

The Finance Committee should support legislation that establishes models for addiction care and financing that are different from traditional grants. The goal is to establish flexibility with public funds to increase access to effective evidence-based addiction treatment.

This new financing mechanism is not intended to replace federal block-grant funding or relieve existing insurers of obligations under the *Mental Health Parity and Addiction Equity Act* (2008). Rather, the goal is to establish an additional financing method that leverages federal dollars and the expertise of private stakeholders who can respond to the rapidly changing demands of the opioid crisis. This supplementary approach would improve the addiction treatment infrastructure to better align with medical/surgical health delivery systems in which the money follows the patient.

Federal block grant funding goes directly to states. While some states can direct funding to the local level for disbursement (for instance to county level agencies), most block grant funding is distributed to individual facility-based providers. This approach bypasses local governments, which are closer to their own challenges and better suited to address them. At the same time, the process bypasses the private marketplace, which is typically more agile in addressing local conditions. We need a patient-focused financing model in which the money follows the patient and is tailored to the individual's clinical needs and choice of treatment, setting and provider.

Under *Cures*, SAMHSA federal block grant funds were directed to for-profit addiction providers, which acknowledged both the need and value of the private sector in addressing the opioid epidemic. We should follow this approach if our country wants to change the current and devastating trajectory of addiction.

NAPHS members and staff are available at your request to provide technical assistance on this bold new approach to opioid funding.

Medicare Beneficiary Opioid Addiction Treatment Act (H.R. 4097)

According to the *Journal of the American Medical Association*, "the population that uses Medicare…has among the highest and most rapidly growing prevalence of opioid use disorder, with more than 6 of every 1000 patients diagnosed and with hospitalizations increasing 10 percent per year." Part of the problem is that while Medicare parts A and D cover methadone, part B does not cover methadone as an outpatient treatment for opioid addiction. The Finance Committee should support legislation introduced from Rep. Richard Neal (D-Mass.) that would allow Medicare beneficiaries to access critical methadone treatment under Medicare part B in outpatient settings.

42 CFR Part 2
Federal regulations dating from the 1970s, commonly referred to as 42 CFR Part 2 or "Part 2," currently govern the confidentiality of medical information about individuals who have applied for or received substance abuse diagnosis or treatment in a program that primarily provides SUD treatment. Part 2 is more stringent (i.e., privacy-protective) than the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA). And when Part 2 is applied to the current digital era, the regulations are an impediment to healthcare integration, which can endanger patients. Finance Committee members should reform Part 2 to improve information-sharing while protecting individuals from using medical records in criminal, civil, and administrative prosecution and discrimination by passing the *Overdose Prevention and Patient Safety Act* (H.R. 3545) and the *Protecting Jessica Grubb's Legacy Act* (S.1850), both of which achieve those goals.

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

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

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

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

Sincerely,

Mark Covall
President/CEO