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September 21, 2017

Governor Chris Christie, Chairman  
President's Commission on Combating Drug Addiction and the Opioid Crisis  
Executive Office of the President  
Office of National Drug Control Policy  
Washington, DC 20503

***Re: Draft Interim Report released July 31, 2017***

Dear Chairman Christie:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks you for your leadership in addressing the nation's opioid epidemic. We appreciate the Commission's recent release of bold recommendations to expand the federal government's response to this devastating public health crisis. The expertise and advocacy of the Commission is vital to guiding federal efforts that will have a substantial and lasting impact. The July draft interim report identifies crucial areas for action and articulates numerous opportunities for significant progress in reducing addiction, overdose and death.

Our comments on the draft report focus particularly on policies that we think can enhance the ability of hospitals, health systems and clinicians to reduce the opioid epidemic. Hospitals are committed to working to end this epidemic. Already, hospitals are implementing standard protocols for prescribing opioids; educating clinicians; promoting the use of state prescription drug monitoring programs; assisting patients by offering treatment or referrals, as appropriate; implementing alternative ways to address pain management; and safeguarding prescription drugs from diversion.

Hospitals are critically aware that they cannot fight the epidemic alone. They are collaborating with their communities to create coordinated responses. They are forming partnerships with other health care providers, state and local departments of health, law enforcement, schools, community organizations and others. Through these collaborations, hospitals have engaged recovery specialists to help patients admitted for drug overdose enter treatment, expanded substance use disorder treatment services, provided training on Naloxone administration, joined with law enforcement to facilitate access to treatment, funded public education programs,



educated community clinicians about prescribing practices, participated in drug take-back days and more. For example, a community in the Shenandoah Valley of rural Virginia came together with its local community hospital and others to create an educational campaign, "Breaking the Code of Silence," to highlight the issue of substance use disorders. The community also installed drug "take-back" boxes at locations across the community. In addition, they developed a transitional care program for individuals who have been incarcerated, established a drug treatment court and created a peer recovery network.

There is much more work to do, and the AHA welcomes the opportunity to engage in a dialogue with the Commission and the staff of the Office of National Drug Control Policy about strategies to prevent addiction, overdose and death, and improve access to treatment. **Of paramount importance in enabling this work is the need to preserve and protect health insurance coverage, including Medicaid. We strongly support the Commission's emphasis on this as part of the goal of treating the whole person.** Effectively treating behavioral health disorders has clinical, social and economic benefits. The U.S. health care system must continue its evolution to incorporate behavioral health services in holistic patient-centered care.

Further, we applaud the Commission's intention to examine workforce and training needs in the final report. A 2015 AHA [report](#) on the state of the behavioral health workforce underscores the critical shortage of behavioral health professionals. We urge you to recommend expanding the workforce to ensure continued access.

We believe that a final report also should support full funding and implementation of recently enacted legislation that helps combat the epidemic, including the Comprehensive Addiction and Recovery Act and the 21<sup>st</sup> Century Cures Act. The Commission should assess the progress in fulfilling these laws' provisions related to federal agency efforts to expand treatment opportunities, promote education and training, reduce stigma and implement parity.

Our specific comments on select recommendations are attached. As noted above, we welcome the opportunity to coordinate further discussions between hospital leaders, Commission members and staff. Please contact me if you have questions or feel free to have a member of your team contact Evelyn Knolle, senior associate director for policy, at (202) 626-2963 or [eknolle@aha.org](mailto:eknolle@aha.org).

Sincerely,

/s/

Ashley Thompson  
Senior Vice President, Public Policy Analysis and Development

Attachment

**AHA COMMENTS ON SELECT PROVISIONS OF THE JULY 31 DRAFT INTERIM REPORT  
OF THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION  
AND THE OPIOID CRISIS**

**Eliminating barriers to treatment caused by the Medicaid Institutions for Mental Disease (IMD) exclusion.** We strongly agree with the Commission's recommendation to grant waiver approvals for all states to eliminate barriers caused by the IMD exclusion. The IMD exclusion prohibits federal financial participation for inpatient psychiatric care for individuals age 21-64 provided in an IMD with more than 16 beds. If the exclusion were eliminated, IMDs could expand access to services for patients with substance use disorders. This would be particularly helpful in improving access to treatment for those with severe or more complex substance use disorders (SUDs). It also could reduce wait times for treatment, and potentially reduce the amount of boarding for patients with both substance use and mental health disorders who would benefit from inpatient treatment. We support efforts to end the IMD exclusion and urge the Commission to reiterate this recommendation in the final report.

**Aligning 42 CFR Part 2 regulations with the HIPAA privacy rule.** We appreciate the Commission's recognition that the regulations at 42 CFR Part 2 governing the confidentiality of SUD patient records creates barriers to sharing information necessary for safe, effective care. The AHA supports legislation to fully align the Part 2 regulation with the Health Insurance Portability and Accountability Act (HIPAA) regulation as the best way to eliminating these barriers.

Recent revisions made by Substance Abuse and Mental Health Services Administration (SAMHSA) to the Part 2 regulations do little to eliminate the barriers that impede the sharing of patient information necessary for delivering the most efficient and effective care. In fact, complete alignment of Part 2 and HIPAA will require statutory changes, and we urge the Commission to support legislation necessary to achieve this outcome in its final report. Applying the same requirements to all patient information – whether behavioral or medical – would support the appropriate information sharing essential for clinical care coordination and population health improvement, while safeguarding patient information from unwarranted disclosure.

**Enhancing medication-assisted treatment (MAT).** A recent [report](#) from the National Academies of Sciences, Engineering and Medicine underscores the gaps in availability of MAT in the U.S. The AHA supports the Commission's recognition of the need to enhance access to MAT, and we have previously [supported](#) efforts to increase patient limits for buprenorphine prescribing. We agree that the federal government should continue to incentivize adequate access to MAT, and in particular we urge the Commission to identify ways to increase the number of providers with specialty training. Among the key challenges for health systems in providing SUD services is finding physicians and psychiatrists with certifications in addiction medicine. Addictionologists, for example, can help oversee MAT programs, directing evidenced-based medicine and serving as a resource for other clinicians, psychiatrists and staff. However, health

systems find themselves constantly recruiting for clinicians with relevant expertise. We support finding ways to make it easy for providers to be trained in MAT to increase access to such treatment.

Other challenges in offering MAT include the time, effort and investment required to start a program, such as recruiting prescribers, training staff and creating record-keeping systems that meet federal legal requirements. We believe it would be beneficial for the federal government, working with stakeholders, to provide resources to assist in the development of MAT programs. For example, SAMHSA or the Centers for Disease Control and Prevention (CDC) could identify or develop a comprehensive, step-by-step guide for physician practices and health systems to set up MAT programs. Numerous resources already exist to provide support for MAT, including the Providers' Clinical Support System, which created a comprehensive electronic repository of training materials and educational resources, as well as a mentoring program, to support MAT. Additional technical support addressing areas such as physician recruitment, staff (non-prescriber) training, regulatory compliance, budgeting, billing and community interaction could facilitate additional interest among health care providers. We envision that such a guide could further address common concerns of clinicians about providing MAT, such as questions that primary care physicians may have about the effects of MAT on their practices. Finally, we also urge the Commission to examine ways to ensure there is adequate coverage and reimbursement for providing MAT services.

**Interstate data sharing among prescription drug monitoring programs (PDMPs).** The AHA supports the Commission's efforts to ensure that PDMP information is shared across state lines. State PDMPs are an important tool in fighting the epidemic, and the nation should seek ways to maximize the capacity of this technology to help clinicians avoid unnecessary or potentially harmful opioid prescriptions. We understand that most PDMPs already engage in some level of information sharing, especially with their neighboring states. In addition to enhancing these efforts, the potential exists to utilize certified electronic health records (EHRs) to improve knowledge about a patient's medications – active and prior. The end goal should support the inclusion of PDMP information in the certified EHR in a timely and efficient manner that is easy for busy clinicians to use in the course of their clinical workflow. We urge the Commission to evaluate and make recommendations about technical and operational changes that make widespread connectivity and access through EHRs possible. We also suggest the Commission address funding sources, continuity plans and long-term success of PDMPs.

**Enhancing parity enforcement.** The AHA applauds the Commission's focus on improving enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). Our members and the patients they serve continue to face obstacles in securing coverage and payment as intended by federal mental health and substance use disorder parity laws. We agree that more must be done to enhance parity compliance, which includes ensuring that parity provisions included in the 21<sup>st</sup> Century Cures Act are fully implemented. New guidance for health plans, improved transparency of benefit information, and additional parity compliance analysis tools can all support better adherence to MHPAEA provisions. Federal agencies, and especially the Department of Labor, must make parity enforcement a priority.

**Mandating prescriber education initiatives.** The AHA strongly supports prescriber education through medical/dental school training, as well as continuing medical education, and has worked to disseminate information to hospitals on opioid prescribing guidelines, such as the CDC guidelines for chronic pain. We also have committed to continue sharing successful hospital practices related to education, prescriber monitoring and alternatives to pain management. We plan to release a toolkit later this fall with additional information and resources for hospitals. While the AHA supports increased prescriber education initiatives, we caution that mandatory requirements can have unintended consequences. We urge you to ensure that any recommendations for mandatory training in the final report undergo thorough debate, such as confirming that an evidence base exists for a mandate's effectiveness; potential conflicts, such as overlapping state requirements, have been identified and addressed; and that a requirement for opioid education, while critically important, will not trigger additional mandates in other areas that have a negative cumulative effect.