

**Statement
of the
American Hospital Association
for the
Committee on Energy and Commerce
of the
United States House of Representatives**

**“Federal Efforts to Combat the Opioid Crisis:
A Status Update on CARA and Other Initiatives”**

October 25, 2017

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, 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) appreciates the opportunity to submit testimony on solutions to address the opioid crisis. We thank you for convening the leadership of key agencies of the Department of Health and Human Services to examine the opioid crisis and the role of federal agencies in responding.

Every day, hospitals witness the devastating effects of the opioid epidemic on the patients and communities we serve. While prescription opioids can be a safe and necessary element of pain management, they also carry serious risks of harm because of the potential for misuse, addiction, overdose and death. The Centers for Disease Control and Prevention (CDC) reported that more than 14,000 people died from overdoses involving prescription opioids in 2014. In 2015, mental health and substance use disorders together were the leading cause of disease burden in the United States, surpassing cancer and cardiovascular disease, according to an infographic



published in the Journal of the American Medical Association. A June 2017 report from the Agency for Health Care Research and Quality found that opioid-related hospital stays increased by 75 percent for women and 55 percent for men between 2005 and 2014, while opioid-related emergency department visits doubled for both men and women.

America's hospitals and health systems play a distinct role in helping to address the opioid epidemic. Our members are working to end this epidemic, employing a multitude of strategies to fight this serious public health problem. They are implementing standard protocols for prescribing opioids, educating clinicians, promoting the use of state prescription drug monitoring programs, offering treatment and referrals to patients, implementing alternative ways to address pain management, and safeguarding prescription medicines from diversion.

At the same time, hospitals recognize that the medical community cannot end the opioid epidemic alone. Success will require sustained collaboration between private and public entities. As one example of such collaboration, last year, the AHA and CDC created a patient education resource on prescription opioids. Developed with input from CDC subject matter experts and hospital clinical and behavioral health leaders, the document provides evidence-based information about the risks and side effects of opioids. Our resource, distributed to all member hospitals and health systems and available through the AHA's website, is designed to facilitate discussions between health care providers and patients about the risks of, and alternatives to, opioids. In addition, the resource includes recommendations on the proper storage of opioids and disposal of unused opioids.

Hospitals and health systems recognize the essential role of federal resources in this effort. The AHA applauds the leadership of the members of the Committee in enacting the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act, and we continue to support full funding and implementation of these laws. We urge you to assess the progress made to date in implementing their provisions, especially those related to expanding treatment, promoting education and training, reducing stigma and enforcing parity. The AHA further urges the Committee to support additional federal initiatives that promote access to comprehensive treatment for opioid-dependent patients and the allocation of adequate resources for such treatment, appropriate data sharing, prescriber education and parity enforcement.

RECOMMENDATIONS

We would like to offer the following actions the government could take to help stem the tide of the opioid epidemic.

First, the AHA continues to urge Congress to eliminate barriers to treatment created by the Medicaid Institutions for Mental Disease (IMD) exclusion, which prohibits federal financial participation for inpatient 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), reducing wait times for treatment, and possibly reducing boarding of patients with substance use and mental health disorders who would benefit from inpatient treatment.

Second, we urge the Committee to support amending 42 CFR Part 2, which governs the confidentiality of SUD patient records and impedes the sharing of patient information necessary for delivering the most efficient and 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 eliminate these barriers. Recent revisions made by the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Part 2 regulations do little to eliminate existing barriers. In fact, complete alignment of Part 2 and HIPAA will require statutory changes, and we urge the Committee to support legislation necessary to achieve this outcome. 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.

Third, the AHA encourages the Committee to enhance access to Medication Assisted Treatment (MAT). A recent report from the National Academies of Sciences, Engineering and Medicine underscores the gaps in the availability of MAT. The AHA has supported efforts to increase patient limits for buprenorphine prescribing. We agree that the federal government should continue to incentivize adequate access to MAT, and we urge the Committee to identify ways to increase the number of providers with specialty training as well. Among the key challenges for hospitals and health systems is finding physicians and psychiatrists with certifications in addiction medicine who can help oversee MAT services, directing evidenced-based medicine and serving as a resource for other clinicians, psychiatrists and staff.

Fourth, the AHA believes that fully employing and connecting prescription drug monitoring programs (PDMPs) – statewide electronic databases that collect designated data on substances dispensed in the state – will bolster federal efforts to combat the opioid epidemic. The AHA supports strengthening PDMPs and ensuring that PDMP information is shared across state lines. The federal government should seek ways to maximize their capacity 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 use certified electronic health records (EHRs) to improve knowledge about a patient’s active and prior medications. We urge the Committee to find ways to support the inclusion of PDMP information in the certified EHR in a timely and efficient manner that is easy for clinicians to use in the course of their clinical workflow.

Fifth, the AHA strongly supports prescriber education through medical and 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.

Finally, the AHA applauds the Committee’s record of commitment to 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, including ensuring that parity provisions in the 21st 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. All federal agencies, and especially the Department of Labor, must make parity enforcement a priority.

CONCLUSION

The AHA thanks you again for your ongoing efforts to address the opioid crisis. Our member hospitals and health systems stand ready to work with you to improve the health of all our communities.