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April 25, 2018

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Dear Chairman Burgess and Ranking Member Green:

On behalf of the American Psychiatric Association (APA), the national medical specialty association representing more than 37,800 psychiatric physicians, we write to offer comments on several of the opioid-related legislative proposals slated for consideration before the House Energy & Commerce Subcommittee on Health. The APA appreciates your leadership on this topic, and as physicians who treat patients with substance use disorders (SUDs), we share your continued concern regarding the opioid crisis' impact on patients, families, and communities. As the Subcommittee moves forward with opioid-related legislation, we offer the following comments for your consideration.

**Access to Medication Assisted Treatment (MAT)**

The American Psychiatric Association (APA) supports expanded coverage and access to MAT for patients with substance use disorders. MAT are proven to be an effective treatment for patients with an opioid use disorder, and most effective when combined with psychotherapy treatments. Thus, MAT should be prescribed as a comprehensive treatment plan that includes counseling and participation in social supports. As you know, Congress passed the Comprehensive Addiction and Recovery Act (CARA) in 2016, which expanded prescribing privileges for MAT to qualifying nurse practitioners (NPs) and physician assistants (PAs) until Oct. 1, 2021 by amending the Drug Addiction Treatment Act (DATA). Given its recent implementation, this is an appropriate timeframe to better understand the impact of expanding prescribing authority to certain practitioners under the law. However, we are concerned with the expanded prescribing authority in H.R. 3692, the "Addiction Treatment Access Improvement Act."

As currently written, H.R. 3692 proposes not only to remove the demonstration date for NPs and PAs to prescribe, but to expand permanent prescribing authority to other practitioners including clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife. This is a permanent expansion of practitioners who have never had prescribing authority for MAT. Consequently, we are concerned H.R. 3692 is fast-tracking prescribing authority to practitioners without understanding the current environment and the potential impact of the change. Moreover, we are concerned patients may not receive optimal care from an expanded list of practitioners, to include appropriate psychotherapy services, which is a vital component of the effectiveness of MAT for opioid addiction. **Therefore, we recommend the Committee not expand prescription authority beyond the current law of NPs and PAs until more data is available relating to the efficacy of the current prescribing authority and any potential unintended consequences.**

#### **Enhancing Collaboration Amongst Providers**

The current patient treatment paradigm, particularly for patients with SUD, is moving towards a system built on effective collaboration amongst multiple health care providers, each practicing in different specialties. However, while APA has always advocated for strong confidentiality protections of patient records, we are concerned that the regulations contained in 42 CFR Part 2 (Part 2) represent a persistent barrier to meeting the whole health needs of patients with SUD.

We were pleased to see the Subcommittee consider H.R. 3545, the “Overdose Prevention and Patient Safety (OPPS) Act.” This important legislation would align Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of health care treatment, payment, and operations (TPO). The APA remains committed to the provision of quality care and protecting patients’ privacy and asserts that this standard can be maintained while allowing for patients to benefit from new models of integrated care by aligning Part 2 with HIPAA for the purposes of TPO. H.R. 3545 retains, and in some instances strengthens, current protections against the use of SUD records outside of TPO, including in civil, criminal, and administrative proceedings or investigations. The APA has long supported this legislation and highlights the importance of ensuring that a treating physician has access to a patient’s full medical record. Compartmentalizing various portions of a patient’s record jeopardizes patient safety by undermining a physician’s ability to provide whole patient care. These barriers also increase the chance of complications related to comorbid medical conditions and/or potentially lethal drug interactions.

In addition, preserving the division between SUD records and all other medical records covered by HIPAA only serves to maintain the perception of SUD as something other than a medical condition and impairs a system of effective collaboration amongst providers. Other conditions that carry stigmas—including HIV and mental illness—are nonetheless included in a patient’s medical record and are covered by HIPAA’s protections. ***We urge the Subcommittee to advance H.R. 3545.***

The Subcommittee is also considering Jessie’s Law (H.R. 5009). If enacted, H.R. 5009 would require HHS to develop and disseminate voluntary best practices regarding the prominent display of a patient’s SUD history in their records, but only as authorized under existing law. It does not contain the enhanced prohibitions against the use of SUD records in civil, criminal, and administrative proceedings, nor does it allow a provider to see a patient’s entire addiction record. ***As such, H.R. 5009 does not resolve the underlying barriers to integrated care created by Part 2.***

#### **Supporting Research for Evidence-Based Treatments**

***The APA supports the Committee’s consideration of H.R. 5002, the “Advancing Cutting-Edge Research Act.”*** If enacted, this legislation would provide the National Institutes of Health (NIH) with the additional tools and flexibility to support innovative medical research to combat the opioid crisis. The APA supports research on alternatives to opioid analgesics as an important component for addressing the opioid crisis. It is also our hope that the development of non-addictive pain treatment options will help mitigate the likelihood that a patient, particularly those with co-occurring depression or other mental health needs, will develop a concurrent substance use disorder.

#### **Enhancing the Workforce of Substance Use Disorder Providers**

Ensuring a robust mental and behavioral health workforce is a critical aspect of any efforts to address the opioid crisis. Unfortunately, there are simply too few clinicians with the requisite knowledge to meet the needs of the the estimated 20.1 million Americans suffering from untreated substance use disorders.

To help meet these needs, we appreciate the Subcommittee’s consideration of H.R. 5102, the “Substance Use Disorder Workforce Loan Repayment Act,” which creates a new student loan repayment program to incentivize an array of health professionals to select career paths that

focus on mental health professional shortage areas. ***The APA supports H.R. 5102 and urges the Subcommittee to advance the bill.***

### **Reducing Barriers to Telemedicine**

Treatment of mental health and substance use disorders via telepsychiatry demonstrates similar—and in some cases, superior—outcomes to in-person care, particularly amongst rural communities, certain cultural groups (such as Native American communities), and individuals with certain diagnoses. Telepsychiatry can also help to mitigate the stigma often associated with seeking treatment for substance use disorders and improve access to psychiatric services in a variety of treatment settings.

The Ryan Haight Act generally prohibits the prescription of controlled substances via the Internet, but contains an exception that allows providers to obtain a special registration to prescribe controlled substances via legitimate telemedicine platforms. Unfortunately, because the Attorney General has yet to promulgate regulations concerning this telemedicine registration provision, many telemedicine and telepsychiatry providers remain in a state of limbo with regard to their patients suffering from a SUD. **Therefore, the APA supports H.R. 5483, the “Special Registration for Telemedicine Clarification Act,” that sets a concrete timeline for the Attorney General to issue these regulations, which represents a critical first step in expanding access to telemedicine.**

Further, the APA supports the draft bill, “Improving Access to Remote Behavioral Health Treatment Act of 2018,” which would help to clarify some, but not all, of the telemedicine exceptions to the Ryan Haight Act. Specifically, while the APA supports the expansion of DEA registration to community mental health centers and therefore allow for the administration of controlled substances through the practice of telemedicine into these centers, as detailed in the bill, it does not entirely help to mitigate the persisting issue of lack of access to psychiatrists in response to the epidemic. The APA believes that activating the special registration for telemedicine for individual practitioners—regardless of the originating site of the patient—should also be contemplated in such legislation.

### **Mental Health Parity and CHIP**

Following Congress’ 10-year reauthorization of the CHIP program, we commend the Subcommittee for its additional focus on H.R. 3192, the “CHIP Mental Health Parity Act.” Access to mental health care remains a critical component of the CHIP program, as approximately 850,000 CHIP beneficiaries experience serious behavioral or emotional disorders. Nearly half of

all diagnosable mental illnesses show symptoms by age 14, and 75% begin by the age of 24. Without early intervention services via the CHIP program, these disorders can lead to tragic and costly consequences, such as substance abuse, school dropout, crime, and suicide.

Unfortunately, ten years after the enactment of the Mental Health Parity and Addiction Equity Act, providers of mental health and SUD services continue to experience disparities in reimbursement, while patients experience disparities in coverage for services. According to the 2017 Milliman report entitled, "Impact of Mental Health Parity and Addiction Equity Act," private insurers in 46 states and the District of Columbia offered plans with higher reimbursement rates for primary care office visits than for behavioral health office visits, while patients seeking behavioral health services were four times more likely to receive treatment from out-of-network providers than those seeking medical or surgical services.

CHIP programs are no exception to this phenomenon, and the existing statutory scheme leaves ambiguity as to whether all CHIP plans are subject to parity requirements under federal law. ***H.R. 3192 clarifies that all CHIP plans are subject to mental health and substance use disorder parity laws, and the APA supports its passage.***

#### **Medicaid Institutions for Mental Diseases (IMD) Exclusion**

We are supportive of the Committee's efforts to expand residential treatment at institutions of mental disease (IMD) for substance use disorder patients covered under Medicaid with a maintenance of effort on other mental health and substance use expenditures. However, we are concerned that the Committee's emphasis on treating patients dealing with substance use disorders excludes the needs of patients who need to access long-term mental health care. ***We recommend that the Committee expand coverage for both patients struggling with a mental illness and/or substance use disorders to receive treatment at an IMD.***

#### **Prescription Drug Monitoring Programs**

The APA supports and appreciates the Committee's efforts to promote information sharing and data transparency efforts among state PDMPs. While we support the expansion of PDMPs and the availability of these programs to share information across state lines, it is important to recognize that PDMPs do not capture all prescription drugs that a patient is taking. If a provider doesn't realize this when they check the PDMP, he or she may inadvertently prescribe contra-indicated medication. ***We recommend PDMPs include a notice to providers that clearly states***

***the drugs excluded from the program (such as methadone), so they can better understand the limitations of the data collected by the PDMP.***

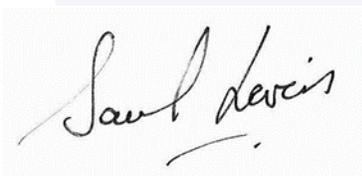
### **Mental Health Care and the Criminal Justice System**

The ongoing discussions concerning the opioid crisis are inevitably tied to issues related to the criminal justice system. According to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental illness, while between one-half and three-quarters of inmates suffer from a substance use disorder. According to a recent study, former inmates within a week post-release were over eight times more likely to die from an overdose than inmates within 90 days to a year following their release.

The APA thanks the Subcommittee for recognizing this aspect of the opioid crisis via its consideration of H.R. 4005, the “Medicaid Reentry Act.” Under current federal law, medical care—including care for the treatment of mental health and substance use disorders—provided in correctional facilities is categorically ineligible for reimbursement under the Medicaid program. If enacted, H.R. 4005 would allow inmates with SUD to receive evidence-based care within 30 days of their release, thereby enhancing former inmates’ ability to successfully re-enter their communities. ***The APA urges the Subcommittee the advance H.R. 4005.***

Thank you again for allowing us to offer our insights on this important legislation, and we look forward to working with the Subcommittee on the development of lasting, impactful solutions. Our Federal Affairs team will follow up with Subcommittee staff on the legislation referenced in this letter. If you have any questions, please contact Megan Marcinko at [mmarcinko@psych.org](mailto:mmarcinko@psych.org) / 202.559.3898 or Mike Troubh at [mtroubh@psych.org](mailto:mtroubh@psych.org) / 202.559.3571.

Sincerely,

A handwritten signature in black ink that reads "Saul Levin". The signature is written in a cursive style with a horizontal line under the name.

Saul Levin, MD, MPA, FRCP-E  
CEO and Medical Director