American Hospital Association™
Advancing Health in America

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The Honorable Paul Tonko
U.S. House of Representatives
2369 Rayburn House Office Building
Washington, DC 20515

The Honorable Mike Turner
U.S. House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Tonko and Turner:

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 respond to your questions about how hospitals and health systems across the country are working to expand access to addiction treatment and what additional steps Congress can take to eliminate the remaining barriers. We thank you for your bipartisan leadership in developing approaches to better meet the nation's behavioral health care needs.

AHA'S WORK ON ELIMINATING BARRIERS TO ADDICTION TREATMENT

Physical and mental health care are inextricably linked, and everyone deserves access to high-quality behavioral health care, including medications for opioid use disorder (MOUD). The AHA has a long history of supporting hospitals and health systems across the country in their work to deliver behavioral health services to their patients and communities. In 2017 we released the first edition of our Stem the Tide toolkit to provide guidance and information to hospitals and health systems on partnering with patients, clinicians and the community to address the opioid epidemic.

In 2020 AHA released the next edition of this work, The Opioid Stewardship Measurement Implementation Guide — with ideas for driving improvements in opioid stewardship within hospitals and health systems and their communities — and The Power of Prevention and Treatment: An AHA Opioid Stewardship Podcast Series to encourage discussion on how hospitals and health systems are improving access to opioid use disorder (OUD) care and what supports are needed to continue to improve care and access for patients and their communities.

Now, in 2024, we are encouraged by the progress to ease barriers to life-saving addiction medicine, but more work remains. AHA, through its affiliate Health Research & Education Trust, was recently awarded a grant to support hospital and health system efforts to strengthen linkage to and retention in care for people with OUD and stimulant use disorder (StUD). Funded by the Centers for Disease Control and Prevention, this project aims to expand evidence-based and evidence-informed efforts to link people to care, treatment and recovery services for OUD and StUD. Specifically, the project seeks to develop resources that bolster cross-continuum collaboration and ultimately improve patient retention in and across three clinical settings: inpatient care, primary care and pharmacy. We will keep you updated on this project in the months to come.

AHA also has been working to reduce the stigma surrounding addiction and seeking treatment for substance use disorders (SUD) by partnering with behavioral health and language experts from member hospitals and partner organizations to release a series of downloadable posters — People Matter, Words Matter — to help create a culture of patient-centered, respectful language for addiction and SUD care. We have heard from our members that these posters have proved to be a valuable addition to their facilities to encourage more respectful dialogue among health care professionals and visitors alike.

AHA Member Case Studies

Nationwide, hospitals and health systems are engaged in extraordinary work to improve access to effective and high-quality treatment for SUDs. We felt it would be helpful to answer your questions by sharing a few examples from our members, in their own words, about what is going well and what challenges remain. Because each program is ongoing, it may have evolved or experienced changes in personnel since publication. We encourage you to take a look at our website for additional podcasts and resources.

- **Hospital Team Sets Patients Up for Successful Treatment and Recovery (Case Study).** The Buprenorphine Team — or B team — was formed at Dell Seton Medical Center in Austin, Texas, in collaboration with Dell Medical School at the University of Texas at Austin. The B team consists of physicians, nurses, pharmacists, social workers, chaplains and other health care professionals who provide information about buprenorphine and the best care for those with SUD.

- **Small Rural Hospital Helps Build 'Bridge' to Addiction Services with New Mobile Clinic (Case Study).** With several key community partners, Greenfield, Mass.-based Baystate Franklin Medical Center established a mobile, home-based treatment service for its rural community located about 100 miles northwest of Boston. Fueled by a $1 million grant from the Health Resources and Services Administration's (HRSA) Rural Communities Opioid Response Program, the Franklin County and North Quabbin Bridge Clinic aims to help meet patients where they are — be it a recovery center, library, a home or the Salvation Army.

- **Partnerships to Address Substance Use Disorders (Podcast).** Presbyterian Healthcare Services is a not-for-profit integrated health system in New Mexico with nine hospitals, a medical group and a health plan. In this podcast, Daniel Duhigg, D.O., medical director for addiction services at Presbyterian Healthcare Services, discusses how their Integrated Substance Use Disorder and Community Collaborative Initiative uses a holistic approach to strengthen and improve outcomes for patients, families and health plan members affected by SUDs.

REMAINING POLICY AND REGULATORY BARRIERS

Bolster Reimbursements for Behavioral Health Providers

Traditional fee-for-service payment systems, including Medicare, inadequately reimburse providers across the behavioral health service continuum. Fee-for-service payment structures rarely reimburse for important time-based (as opposed to procedure-based) elements of behavioral health care, such as coordinating care across providers and settings or for care management that does not occur face-to-face, including referrals and case management. Current reimbursement levels also reflect an undervaluing of behavioral health services, which may require more evaluation, clinical expertise and time than certain medical services. For example, unlike anemia, schizophrenia cannot be identified with a blood test; similarly, diagnostic imaging can reveal broken bones but not depression. Because identification, diagnosis and treatment of behavioral health disorders often involve using multiple tools and therapies, a simple fee-for-service payment structure cannot capture the wide span of costs incurred by behavioral health specialists. In addition, separate funding streams and benefit structures for psychiatric and SUDs create barriers and limit the integration of behavioral health care with other medical and surgical services. This is particularly true for the Medicaid program, the largest payer of behavioral health care.

In addition to underpaying for care and thus limiting providers' ability to take on new patients, it is important to consider how low reimbursement rates may discourage the recruitment and retention of the next generation of behavioral health professionals required to serve the growing need for behavioral health care.

Repeal the Institution for Mental Diseases Exclusion

As Congress continues to look for ways to improve access to needed SUD treatment services for Americans and to reduce the stigma associated with these health conditions, we encourage you to permanently repeal the Institution for Mental Diseases (IMD) exclusion of federal Medicaid funding to pay for inpatient behavioral health treatment (including SUD and mental health services) in certain inpatient facilities. SUD treatment requires access to the full continuum of care, including inpatient care, partial hospitalization, residential treatment and outpatient services. Different types of patients require different clinical services across the care continuum, and the IMD exclusion currently blocks critical elements of that care. These patient populations include adolescents, pregnant women, individuals with unstable housing, people with high relapse potential, and individuals who have OUD or other SUDs with co-occurring alcohol or benzodiazepine addictions. Investing only in outpatient or community-based care and failing to provide states with relief from the IMD exclusion would continue to deny many of these patients access to the most clinically appropriate care. To alleviate the dire shortage of inpatient psychiatric beds, **Congress should permanently repeal the IMD exclusion to allow federal Medicaid dollars to pay for clinically appropriate inpatient care.**

Remove the 190-day Lifetime Limit

As we work to better address the nation's health needs by further integrating physical and behavioral health, the 190-day lifetime limit on coverage under Medicare is another remaining antiquated obstacle. Medicare currently covers only 190 days of inpatient care in a psychiatric hospital in a person's lifetime. No other Medicare specialty inpatient hospital service has this type of arbitrary cap on benefits. For many patients, chronic mental illness will be a lifelong journey and could far exceed 190 days of inpatient treatment, leaving them to rely on other sources of financing (including Medicaid and Social Security) to pay for long-term services in non-psychiatric settings that may be inadequate for their care.

With the nation's population aging and an increasing number of seniors and people with disabilities seeking inpatient care to address their behavioral health needs, now is the time to repeal this outdated and discriminatory policy and ensure that Medicare beneficiaries can receive necessary inpatient psychiatric care. **The AHA supports bipartisan legislation such as the Medicare Mental Health Inpatient Equity Act of 2023 (H.R. 4946) to remedy this discriminatory policy.**

Repeal In-person Telehealth Requirement for Behavioral Health

Behavioral health is one specialty that has seen sustained growth in telehealth utilization. In fact, prior to the pandemic, telehealth visits accounted for less than 1% of behavioral health visits. During the pandemic, they peaked at about 40% of all

behavioral health visits and have been sustained at around 36%.[1] There continues to be an increasing demand for behavioral health services, but additional flexibilities are required to ensure the people who need them most can access these services.

The Consolidated Appropriations Act of 2021 requires that a patient must receive an in-person evaluation six months before they can initiate behavioral telehealth treatment, plus an annual in-person visit. From an access perspective, requiring an in-person visit six months before and annually after may serve as an additional barrier to receiving care, particularly for patients in rural or underserved areas.

The progression to a permanent pathway for waiving in-person visits has been delayed due to concerns about diversion risk. We recognize and appreciate the important role the Drug Enforcement Agency (DEA) plays in mitigating the diversion risk. However, significant data demonstrates that increased access to MOUD is only associated with improved outcomes, not increased misuse risks, and any diversion risks can be mitigated with efforts already in place.[2] The DEA relies on a general assumption that because controlled substances *can* be misused, an increase in access results in increased risk. This assumption not only overstates the risk of diversion but also fails to consider the millions of Americans who may be harmed by an inability to access medically necessary medication through virtual prescribing. **In many cases, seeing a provider in person is simply not an option for some patients, whether due to physician shortages, mobility issues or transportation challenges.** For example, there is a national shortage of psychiatrists and other behavioral health providers; indeed, according to HRSA, 123 million people live in a mental health provider shortage area, and the American Psychiatric Association projects a shortage of over 12,000 psychiatrists by 2030.[3,4] Therefore, remote services are becoming increasingly important to link geographically dispersed patients to prescribers for medications like buprenorphine.

Establish DEA Special Registration Process for Telemedicine for Administration of Controlled Substances

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 outlined specific requirements for in-person evaluations prior to prescribing controlled substances. In conjunction with these requirements, this law also outlined seven categories where

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[1] Centers for Disease Control and Prevention. "Increased Use of Telehealth for Opioid Use Disorder Services During COVID-19 Pandemic Associated with Reduced Risk of Overdose." CDC Online Newsroom, August 31, 2022. https://www.cdc.gov/media/releases/2022/p0831-ccovid-19-opioids.html
[2] Gary Qian, Keith Humphreys, Jeremy D. Goldhaber-Fiebert, Margaret L. Brandeau. "Estimated effectiveness and cost-effectiveness of opioid use disorder treatment under proposed U.S. regulatory relaxations: A model-based analysis." Drug and Alcohol Dependence 256 (2024). https://www.sciencedirect.com/science/article/abs/pii/S0376871624000334?via%3Dihub
[3] https://data.hrsa.gov/topics/health-workforce/shortage-areas
[4] https://www.psychiatry.org/psychiatrists/advocacy/federal-affairs/workforce-development

telemedicine could be utilized, including but not limited to public health emergencies (PHEs) (the basis for the waiver during COVID-19), a special registration obtained from the attorney general, and other circumstances to be defined by regulation. The Ryan Haight Act went on in Sec. 311(h)(2) to specify that the attorney general shall promulgate regulations specifying circumstances in which a special registration for telemedicine prescribing may be issued and the procedures for obtaining such a special registration. In other words, it was never the intention of Congress to permanently and unilaterally restrict access to telemedicine prescriptions of controlled substances issued by legitimate prescribers for clinically appropriate purposes.

The SUPPORT Act of 2018 again mandated that the DEA, in coordination with the Department of Health and Human Services, promulgate special registration final regulations specifying: (1) the circumstances in which a special registration for telemedicine may be issued that authorizes prescribing of controlled substances without an in-person evaluation; and (2) the procedure for obtaining a special registration. The COVID-19 pandemic provided an opportunity for the DEA to learn from the broad utilization of telemedicine prescribing and set forth policies and pathways for providers to continue to safely administer prescriptions virtually, even after the PHE period ended. **Unfortunately, despite the Ryan Haight Act requirement that the DEA establish a special registration process *nearly 16 years ago*, and subsequent reinforcement of this requirement over five years ago in the SUPPORT Act, the agency still has not created one.**

We ask Congress to consider the following:

- Continue to urge the DEA to require proposed and final rulemaking from agencies for the special registration for telemedicine regulation.
- Grant a permanent exception for separate registrations for practitioners in states with medical licensing reciprocity requirements.
- Require agencies to provide a proposed interim plan if there is ever a gap in PHE waivers and rulemaking.

Medication-assisted Treatment in Emergency Departments

To help prevent SUD relapses, Congress can also provide additional support for programs that fund hospital efforts to initiate medication-assisted treatment (MAT) in emergency departments (EDs). The SUPPORT Act requires Medicaid programs to cover MAT from October 2020 through September 2025, and it expands certain providers' ability to treat up to 100 patients in the first year of receiving a waiver. However, access to these programs remains limited. The AHA supports making this change permanent, as well as expanding grant funding for hospitals and other entities to enable the development of protocols for discharging patients from the ED who have overdosed on opioids, which may include providing MAT, connecting patients with peer support specialists, and supporting referrals to community-based treatment.

Eliminate Prior Authorization for MOUD

Millions of Americans rely on commercial insurers for their health care coverage, including Medicare Advantage (MA) plans through the Medicare program. Unfortunately, practices such as prior authorization can result in inappropriate denials, additional burdens on providers and ultimately delays in a patient's access to needed care.

The AHA remains particularly concerned with current prior authorization practices for MAT that are not evidence-based and lack uniformity with insurers. Because many mental health services are more time-based than physical health services, with fewer quantitative ways to measure outcomes, these processes take a disproportionate toll on behavioral health services. Studies have shown that, compared with patients whose insurance did not impose prior authorization restrictions on their medication, odds of treatment effectiveness were 19-29% lower due to lack of medication adherence.[5] Payer practices that restrict access to care include overly broad use of prior authorization, automatic denials (most of which are overturned upon appeal), inappropriate delays of approvals, and insufficient provider networks.

To address these practices within MAT, Congress should:

- **Require** a list of drugs subject to prior authorization that is uniform across insurers to provide consistent information to patients and providers.
- **Make clear** that coverage across the entire treatment spectrum is necessary (rather than requiring prior authorization each time the prescription is filled).
- **Pass** comprehensive legislation to streamline prior authorization requirements such as the Improving Seniors' Timely Access to Care Act.

Strengthen the Health Care Workforce

The chronic underfunding for behavioral health services has hampered hospitals' and health systems' ability to retain critical staff, especially as the financial pressures of the past several years further eroded hospitals' ability to subsidize these services. As the need for behavioral health services continues to rise, the nation is ill-prepared to respond to these needs due to severe shortages in the behavioral health workforce. A key action needed to support and expand the behavioral health workforce is the elimination of policies that make it harder for existing providers to treat patients.

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[5] Boytsov, N., Zhang, X., Evans, K.A. *et al.* Impact of Plan-Level Access Restrictions on Effectiveness of Biologics Among Patients with Rheumatoid or Psoriatic Arthritis. *PharmacoEconomics Open* **4**, 105–117 (2020). https://doi.org/10.1007/s41669-019-0152-1

Reducing barriers to licensure can help maximize limited provider capacity, particularly in areas with shortages of practitioners. **The AHA supports efforts to ensure that licensure processes are streamlined for providers employed by hospitals and health systems operating across state lines and encourages additional research on the feasibility, infrastructure, cost and secondary effects of licensure.**

We are committed to working with the health care field, Congress and the Administration to address long-term workforce. The AHA recommends the following suggestions to support the behavioral health workforce:

- **Reauthorize** the Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program.
- **Invest** in graduate medical education and increase slots for behavioral health in underserved areas.
- **Streamline** and simplify licensure application and processing by reducing the variability of scope-of-practice laws and support changes that drive integration of care teams.

CONCLUSION

We thank you for your leadership and dedication to finding bipartisan solutions to address these important issues. As you know, there is still more work to be done to reduce barriers to receiving and administering behavioral health services, and we look forward to working with you on these future efforts.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President, Legislative and Political Affairs