CENTERSTONE

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CENTERSTONE AMERICA

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

UNITED STATES HOUSE OF REPRESENTATIVES

"COMBATTING THE OPIOID CRISIS: IMPROVING THE ABILITY OF MEDICARE AND MEDICAID TO PROVIDE CARE FOR PATIENTS"

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CENTERSTONE

I. ESTABLISH A STANDARD OF CARE FOR COMPREHENSIVE ADDICTION TREATMENT

Today, there is no set path a provider is encouraged to follow in treating a patient with an opioid use disorder (OUD) or a substance use disorder (SUD). No one is holding that provider accountable for administering evidence-based protocols, or for ensuring that patients achieve positive outcomes. Standards of quality care have not been widely accepted, so no consistent protocols for care currently exist across our Nation. Therefore, we must establish a standard of care for comprehensive addiction treatment so that individuals across the country may have access to the same standard of care, no matter where or when they seek help.

To this end, Centerstone recommends **developing a "gold standard" certification that would establish "clinical excellence hubs**" as preferred providers for courts, corrections, emergency departments, etc. for trusted patient referrals. These clinical excellence hubs would need to demonstrate use of evidence-based interventions, linkages to a full continuum of care, including services geared towards increasing patients' recovery capital[1], and report on patient outcomes. As an incentive, excellence hubs could be eligible for federal funds upon a showing of successful implementation and reporting on well-vetted and defined treat-to-target metrics.

The **Comprehensive Opioid Recovery Centers Act (H.R.5327)** is an appropriate legislative vehicle to bring about this shift. The bill would authorize SAMHSA to award 3-5 year competitive grants to eligible entities that met certain quality and procedural standards in providing SUD services.

OUD, SUD, and other behavioral health conditions are chronic diseases. 6 out of 10 people with an SUD also suffer from another form of mental illness.[2] People with OUD or SUD tend to also suffer from other physical ailments. Due to these comorbidities, health homes are particularly effective in treating patients with behavioral health disorders because they provide whole-person care. Centerstone has developed and implemented its very own patient centered health homes in Indiana, Illinois, Kentucky, and Tennessee to provide integrated, patient-centered care to consumers with co-occurring, complex conditions. Through our health homes, Centerstone has achieved

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2211734/

[2] https://www.chcs.org/media/HH-IRC-Health-Homes-for-Opioid-Dependency.pdf

demonstrable outcomes within our patient population: 84% of our patients with high blood pressure saw lower readings after 12 months; recipients also reported a 56% improvement in anxiety levels and a 53% improvement in general health. Participants awarded this model a 98% approval rating.[3] Health homes can improve patient outcomes at a significant cost savings.

The federal government can help spur innovation in whole-person, integrated care via the **Medicaid Incentives for Health Homes to Treat Substance Use Disorder (H.R.___)** bill.

Though health homes are effective in treating complex patient populations efficiently, providers across the country are coming up with diverse ways to treat their own patient populations. Providers should be afforded the latitude to develop and test new care models that put patients first. The federal government should **incentivize value-based, integrated addiction treatment models**. At Centerstone, for example, we are developing a "Per Member Per Month" (PMPM) model for outpatient treatment within our *recovery oriented medication assisted treatment (RO-MAT)* framework.[4] This model requires treating the patient holistically, building their recovery capital, and for the majority of our patients, working toward a discontinuation protocol from medication assisted treatment.

The **Alternative Payment Model for Treating Substance Use Disorder (H.R. ___)** would allow providers the requisite flexibility in designing and implementing whole-person treatment models without the reimbursement barriers of our predominantly fee-for-service system.

As it currently stands, fee-for-service contracts infrequently reimburse for key services within the continuum of care. As the evidence-base evolves, fee-for-service contracts are slow to keep up with research findings on best practices. For example, the use of peers in emergency rooms have been shown to be an effective way to engage patients during a narrow window of opportunity when they may desire to start pursuing treatment.[5] Research indicates that use of peer supports leads to significant decreases in substance use, symptom improvement, and better management of patients' own conditions.[6] These outcomes are largely achieved by a sense of trust,

[3] https://centerstone.org/our-resources/health-wellness/what-is-a-health-home
[4] https://centerstone.org/blog/research-institute/centerstone-integrated-addictions-care-and-our-3-promises
[5] Bassuk, E., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63*, 1-9.
[6] Crane, D. A., Lepicki, T., & Knudsen, K. (2016). Unique and common elements of the role of peer support in the context of traditional mental health services. *Psychiatric Rehabilitation Journal, 39*(3), 282-288.

supportive accountability, and by the non-judgmental attitude peers exhibit towards patients.[7] As a result of the opioid epidemic, Centerstone has seen a dramatic uptick in hospital requests for our mobile crisis services. Mobile crisis services entail a licensed counselor, case manager, or peer specialist travelling to an emergency department where an individual typically presents after an overdose, to engage an individual in their recovery. Staff time in transit to and from an emergency department, staff mileage, as well as emergency department engagement services, however, are not typically adjusted for in our reimbursement rates. Fortunately, Centerstone staff in several of our footprint states have recently been able to provide these services thanks to 21st Century Cures STR grants.

This represents a particular example of why the **Alternative Payment Model for Treating Substance Use Disorder (H.R. ___)** bill is important to behavioral health providers in offering up-to-date evidence-based care. Additionally, the **Preventing Overdoses While in Emergency Rooms Act of 2018 (POWER Act) (H.R.5176)**, which would authorize the Secretary of HHS to award grants to eligible health care sites to deploy coordinated care to patients presenting with SUD in emergency departments could enable providers to utilize peers in a meaningful way within the greater continuum of care.

As a Nation, we need to take steps to ensure that evidence-based treatments are available in all communities, and that we are not inadvertently supporting sub-standard care. The federal government can incentivize high standards in care delivery by tying federal dollars to evidence-based services only.

Specifically, **reimbursement protocols should reward trusted providers who work systematically to improve patient outcomes.** Lawmakers should take steps to ensure that federal dollars are not misused by inadvertently flowing federal funds to "MAT pill mills[8]," which offer suboptimal care to patients and may even exacerbate the problem dedicated providers are aiming to fix. Furthermore, as more rogue actors move into this space, quality providers are experiencing increasing levels of denials while administering sound, evidence-based addiction treatments to individuals. Medical staff in several of our accredited addiction treatment facilities across several states are increasingly forced to navigate tremendous administrative hurdles; for instance, they report record levels

[7] Behler, J., Daniels, A., Scott, J., & Mehl-Madrona, L. (2017). Depression/bipolar peer support groups: Perceptions of group members about effectiveness and differences from other mental health services. *The Qualitative Report, 22*(1), 213-236.
[8] https://www.courier-journal.com/story/news/investigations/2017/06/08/rogue-doctors-hands-medicine-designed-treat-addiction-turns-into-new-habit/98522426/

of Medicaid and commercial insurance denials and prior authorizations for OUD treatment and, in some cases, report being asked to submit upwards of 70 pages of clinical documentation for treatment of *a single patient*. This disconnect between quality and reimbursement has fostered an environment in which predatory MAT prescribers thrive and quality providers – those committed to offering a full continuum of care mirrored after nationally recognized clinical models – are backed into a tight financial corner. This reality causes millions of dollars to be spent on claims management instead of patient care. To safeguard against this, Centerstone recommends that **federal dollars only flow to providers of evidence-based services.** Providers serving OUD and SUD populations should demonstrate the ability to offer a comprehensive continuum of evidence-based services before receiving taxpayer dollars. Payment models should be linked to standardized outcomes and designed to incentivize integrated, whole-person care models for addictions treatment, particularly for patients with co-occurring and complex conditions.

The **Reinforcing Evidence-Based Standards Under Law in Treating Substance Abuse Act of 2018 (RESULTS Act) (H.R.5272)** is a straightforward mandate to tie federal dollars to evidence-based services only. To ensure Congress and the public is properly and timely informed on services that prove either effective or ineffective, the bill to **Require state Medicaid programs to report on the 10 behavioral health measures that are included in CMS' 2018 Core Set of Adult Health Care Quality Measures for Medicaid (H.R. ___)**, as well as the **Improving Medicaid Timeliness Act (H.R. ___)** are legislative tools that could bring about the more consistent gathering, reporting, and analyzing of critically important behavioral healthcare data.

II. OPTIMIZE THE BEHAVIORAL HEALTH WORKFORCE

We know that there are more than 30 million people living in rural communities in which no treatment options of any kind exist today – let alone comprehensive, evidence-based ones.[9] By the year 2025, workforce projections estimate that there will be a workforce shortage in the fields of substance abuse and mental health

[9] National Rural Health Association

treatment of approximately 250,000 providers across all disciplines.[10] In 2013, all nine types of behavioral health practitioners had shortages. Currently, six provider types have estimated shortages of more than 10,000 FTEs, including psychiatrists, clinical and counseling psychologists, substance abuse and behavioral disorder counselors, mental health and substance abuse social workers, and mental health counselors.[11] With immense gaps in treatment access and fatal opioid-related overdoses at an all-time high,[12] it is imperative that we take steps to address from multiple angles.

Licensed marriage and family therapists (LMFTs) and licensed mental health counselors (LMHCs) hold licensures on par with license clinical social workers (LCSWs), yet their exclusion under Medicare is somewhat arbitrary. As a result of this workforce gap, providers face significant barriers when recruiting within the limited allowable provider types, particularly in rural areas. This shortage in eligible workers also results in wait times that can be 4 times higher amongst Medicare patients, as opposed to under Medicaid, which permits for reimbursement of LMHC and LMFT services in some of our sites.

The **Mental Health Access Improvement Act of 2017 (H.R.3032)** would allow LMFT and LMHC services to be reimbursed by Medicare. This bill would enable faster access to care for Medicare and some commercial patients, as well as optimize our current workforce to operate at the top of its licensure.

Peer support services are currently accepted as evidence-based practices by both CMS and SAMHSA. These services are currently reimbursable under Medicaid. Therefore, certified peer supports should gain the ability to serve SUD patients under Medicare. Though peers serve as a vital "connective tissue" in the continuum of care, certified peer supports should be utilized in the context of a broader continuum of care, managed by a licensed addiction or mental health specialist to ensure patients receive appropriate evidence-based treatment planning, treatment intensity, services, and receive treatment for the proper length of time. The recognition of peer support specialists in Medicare will likely spur commercial plans to advance access to this type of provider in the future.

The **bill to support the peer support specialist workforce (H.R.___)** may serve as an appropriate legislative vehicle to bring about this goal.

[10] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf
[11] https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf
[12] https://www.cdc.gov/vitalsigns/opioid-overdoses/

According to a 2018 State of Workforce Management Survey, the top priority for behavioral health not-for-profit providers is recruiting and retaining top talent, with the primary challenges being (a) an inability to offer competitive pay and benefits, and (b) a lack of qualified applicants. The **Substance Use Disorder Workforce Loan Repayment Act of 2018 (H.R.5102)** would function to directly alleviate the supply problem because it would provide a loan-repayment incentive to individuals choosing to practice in workforce shortage areas. The bill would authorize the HRSA to pay up to $250,000 of an individual's program loan obligations for those who complete a period of service in an SUD treatment job in a mental health professional shortage area or in a county particularly badly impacted by the opioid epidemic.

Telehealth has a dual purpose of both connecting patients to lifesaving care that may have previously been beyond their physical reach, and also of reducing the effects of a behavioral health workforce shortage. Lawmakers should **fully optimize the value of our behavioral health workforce by affording them a wider latitude to treat SUD patients via telemedicine**. A Medicare provider can only be reimbursed for telehealth services if the patient is located at a specified "originating site" – a restriction that clearly limits the purpose of telehealth. The **Access to Telehealth Services for Opioid Use Disorders Act (H.R.___)** would allow HHS to waiver certain telehealth requirements for eligible practitioners providing SUD services to Medicare patients diagnosed with an SUD. By essentially waiving the "originating site" restriction for certain Medicare patients, this bill will expand the number of providers that are able to treat the elderly in their own home, and will significantly improve access to addiction treatment services to these patients.

The Ryan Haight Act makes it illegal for a practitioner to issue a prescription for a controlled substance via telemedicine without having first conducted at least one in-person medical evaluation of the patient. There are currently three FDA-approved medications for the treatment of opioid use disorder: naltrexone, methadone, and buprenorphine.[13] These medications are recognized by the National Institute of Drug Abuse,[14] American Society of Addiction Medicine,[15] and the Substance Abuse and Mental Health Services Administration[16] as essential tools

[13] Dr. McCance-Katz, Oral Testimony, November 13, 2017. http://www.aei.org/events/the-opioid-crisis-what-can-congress-do-a-conversation-with-house-committee-on-energy-and-commerce-chairman-greg-walden-r-or/
[14] https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview
[15] https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24#search="medication assisted treatmetn"
[16] https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

in responding to the opioid epidemic. Under current law, non-SAMHSA practitioners who wish to prescribe Suboxone (brand name for buprenorphine) to a patient they are treating via telemedicine would need to first perform an in-person evaluation, had they not already done so. Following this regulatory mandate for buprenorphine prescribing, however, may be overly burdensome in many circumstances, and may prevent many patients from receiving life-saving treatment. Thus, we recommend that **licensed community mental health and addiction providers, who follow nationally recognized models of treatment, gain access to a special registration process so that they may register with the DEA to prescribe substances now commonly embraced in MAT practice, without a prior in-person patient/provider encounter**.

To bring about this end, we support the **Special Registration for Telemedicine Clarification Act of 2018 (H.R.___)**, which calls for the promulgation of interim final regulations on the topic of special registration for health care providers to prescribe controlled substances via telemedicine without the initial in-person contact. Additionally, the **Improving Access to Remote Behavioral Health Treatment Act of 2018 (H.R.___)**, which mandates final regulations on the topic of community mental health centers registering with the DEA to prescribe controlled substances via telemedicine, is an important step in getting "all hands on deck" to alleviate the supply shortage and improve access to care.

III. MODERNIZE OUR NATION'S BEHAVIORAL HEALTH INFRASTRUCTURE

Behavioral health providers will be slow to tackle to opioid epidemic without a significant improvement and modernization in our information technologies. Investments in the health IT backbone of our behavioral health care delivery system are a critical tool in improving care and moving our industry from one that is siloed and inefficient to one that is integrated and provides whole-person care.

The Confidentiality of Substance Use Disorder Patient Records rule – 42 CFR Part 2 – is a stringent rule that prevents providers from systematically treating OUD/SUD patients in reliance on complete and accurate patient histories. **In moving towards more robust integrated care models where every member of a patient's treatment team needs to understand a patient's full medical/SUD history, Part 2 stands as a hindrance to whole-person care**. Part 2 has never been applied universally: only federally assisted alcohol and drug abuse programs providing SUD diagnosis or treatment are subject to the stringent Confidentiality of Substance Use Disorder Patient Records rule – 42 CFR Part 2.[17,18] Part 2 prevents these federally funded providers from accessing a patient's full substance use history without the patient's prior written consent. In contrast, non-federally assisted providers throughout the country are governed only by HIPAA. Re-disclosures of protected patient information occasionally cited by patient privacy groups are currently illegal. Thus, improper re-disclosures of information are not a reflection of a weak privacy law, but rather, are a reflection of improper on-the-ground practice, which can be challenged in court. Thus, we urge lawmakers to **align 42 CFR Part 2 with HIPAA for the purposes of treatment, payment, and health care operations**. Common sense legislation like **The Overdose and Patient Safety Act (H.R. 3545)**, would align Part 2 with HIPAA for the purposes of *treatment, payment, and health care operations*, and strengthen protections against the use of substance use disorder records in criminal proceedings. The Amendment in the Nature of a Substitute to H.R. 3545 has strengthened language regarding penalties for improper re-disclosures. Centerstone supports that added language, but stresses the need for the statutory alignment to be for purposes of treatment, payment, and healthcare operations, and not solely for the purposes of treatment (as in the AINS).

"Limited data exists to track the [opioid] crisis and identify weaknesses in current responses (e.g. prescribing practices, treatment availability, individuals at risk), but is held in different databases across a multitude of public and private organizations, and significant proportion is not in real-time."[19] A **national standard for an interoperable, real time prescription drug monitoring program (PDMP)** would address these challenges, and would also help providers identify patients who may be at risk for opiate abuse. Technology and standards are

[17] https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf
[18] http://www.jhconnect.org/wp-content/uploads/2013/09/42-CFR-Part-2-final.pdf
[19] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

available today across the country that have the ability to inform, standardize, and enhance the information that is available to clinicians at the points of prescribing and dispensing. PDMPs are crucial sources of data for providers.

Regarding interoperability, PDMPs are profoundly different across state lines and in how they are integrated with health IT in each state. **Improving interoperability of PDMPs will allow providers the ability to check patient prescription histories, alert providers to individuals with patterns indicative of misuse, and prevent patient doctor shopping**.

Regarding the timeliness of information transferred, PDMPs currently run on batched information, only being utilized retroactively to track dispensing data for patients. **If PDMPs ran real-time, many prescriptions would not be dispensed; others would never be written.** Checking a real-time PDMP would allow a clinician to not only stop the medication from potentially falling into the hands of an individual exhibiting addictive behaviors, but to address those potential harmful behaviors and help refer to treatment or alternate therapies, something we term a "warm hand-off."

Currently, in order to check a state's PDMP, most clinicians are required to log in to a system separate from their normal medical record software (EHR, prescription dispensing system, etc.), query the site, analyze the report results, and then return to their original workflow. **To facilitate real-time access to data and reduce prescriber burden, patient data must be accessible within workflow.**

Finally, we suggest capitalizing on PDMP technologies and leveraging them to be more than simply a data-gathering tool; any **national PDMP standard should link patients to treatment by automating, or incenting, a *Screening, Brief Intervention and Referral to Treatment* (SBIRT) function** in order to help providers catch patients who may otherwise fall through the cracks. SBIRT is an evidence-based preventative measure designed to move patients, who may need help, into treatment. SBIRT uses tools like Motivational Interviewing to identify those at risk for developing an SUD and help those who already have an SUD. Generally, SBIRT increases an individual's chance for early intervention and access to treatment. By linking SBIRT functions to a PDMP system, we would not only be able to "flag" at risk patients, but also screen and refer them to appropriate treatments.

There are several legislative proposals on the topic of PDMPs: the **Prescription Drug Monitoring Act of 2017 (H.R.1854)**, the **bill to enhance and improve state-run prescription drug monitoring programs (H.R.___)** introduced by Reps Griffith and Pallone, and **the Medicaid PARTNERSHIP Act (H.R.___).** Each of these proposals has strengths and weaknesses, but none address all of the core challenges we see in the current system nationwide: lack of interoperability among states or with other health IT, data latency, data not within workflow for providers and dispensers, and unable to trigger SBIRT. We recommend that the final PDMP proposal address each of these challenges.

Unfortunately, there will be little or no data sharing among Medicare, Medicaid and state initiatives, such as PDMPs, unless robust electronic health records (EHRs) are universally adopted and used by substance use and mental health providers. EHRs and related connectivity services are increasingly the means by which data is shared. Community Mental Health Centers (CMHCs) like Centerstone know that the optimal way to treat mental illness and substance use disorders is to couple those behavioral health services with primary care, which, in effect, treats the whole person with comprehensive, multidisciplinary services systematically combined to provide the best outcomes. **Information technology provides the vital link** in this process by facilitating the exchange of authorized health data between care providers. Providing technology-enabled coordinated, integrated care to OUD/SUD patients can enhance outcomes, improve efficiency, and lower costs across the entire healthcare spectrum. **Thus, value-based care requires building an expanding set of technological capabilities, such as interoperable EHRs.**

Unlike the majority of the health care system, however, substance use providers were not eligible for financial incentives to bolster their EHRs under the HITECH Act.[20] Though behavioral health providers know the short and long-term benefits of utilizing robust technologies, these providers often operate on very narrow profit margins, thereby making up-front investments in robust EHR technologies extremely challenging, or even impossible. Thus, the **bill to amend title XI of the Social Security Act to promote testing of incentive payments**

[20] Medicaid and CHIP Payment and Access Commission. (2018). [Public meeting transcript]. Retrieved from https://www.macpac.gov/wp-content/uploads/2017/07/January-2018-MACPAC-Meeting-Transcript.pdf

for behavioral health providers for adoption and use of certified electronic health record technology (H.R.3331) would authorize CMMI to distribute incentive payments to behavioral health providers, such as psychiatric hospitals, Community Mental Health Centers, psychologists, social workers, and addiction treatment providers, for adopting and using certified EHR technology to improve care coordination.

On behalf of all of us at Centerstone, we ***Thank You*** for your attention to the opioid crisis. We look forward to working closely with you to find ways the federal government can help us save and improve the lives of Americans across our country.

Sincerely,

David C. Guth, Jr.
CEO, Centerstone America