STATEMENT FOR THE RECORD

Submitted to the
House Energy and Commerce Committee
Subcommittee on Health

H.R. 3545, the Overdose Prevention and Patient Safety Act

May 8, 2018

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
Suite 500, South Building
Washington, D.C. 20004

America's Health Insurance Plans (AHIP) appreciates this opportunity to express our strong support for proposed legislation, H.R. 3545, which would allow the confidential sharing of information on substance use diagnosis and treatment information to protect patient safety, improve health care quality, and enhance care coordination.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Our members have played a leadership role in addressing the opioid crisis, drawing upon the deep expertise of their chief medical officers, behavioral health clinicians, pharmacists, and policy staff. Together with our member plans, AHIP has launched a Safe, Transparent Opioid Prescribing (STOP) Initiative[1], through which we are supporting the widespread adoption of clinical guidelines for pain care and opioid prescribing. This initiative includes a STOP Measure[2] to assess adherence with the Centers for Disease Control and Prevention's (CDC) guideline for opioid prescribing and a STOP Playbook[3] outlining steps relating to prevention, early intervention, and treatment of opioid use disorders.

AHIP and Our Members Strongly Support H.R. 3545

As part of our broadly focused strategy for tackling the opioid crisis, our members strongly support H.R. 3545, the "Overdose Prevention and Patient Safety Act." This bipartisan bill would align existing federal regulations (42 CFR Part 2) that set requirements for patient consent and related notice requirements for substance use disorder information with the Health Insurance Portability and Accountability Act's (HIPAA) existing privacy requirements for uses and disclosures of individuals' health information for treatment, payment, and health care operations. In other words, this legislation would require that the medical records of patients with substance use disorders (SUDs) be treated exactly the same as the medical records of patients with other chronic illnesses.

[1] https://www.ahip.org/ahip-stop-initiative/
[2] https://www.ahip.org/the-stop-measure/
[3] https://www.ahip.org/stop-playbook/

This is an important step toward improving care coordination, patient safety, and health outcomes for patients struggling with opioid addiction and other SUDs. By ensuring appropriate access to a patient's entire medical record (including addiction-related information), this legislation would ensure that health care professionals and health insurance providers have all the information necessary for safe, effective, high quality treatment and care coordination to address the full scope of a patient's health care needs.

By contrast, the current federal regulations (42 CFR Part 2) can serve as a barrier to whole-person, integrated approaches to care that produce the best health outcomes for patients. By limiting access to critical patient information, the current rules can impede the integration of services and supports for patients. This, in turn, can lead to patient harm, including problems with contraindicated prescriptions and medication adherence.

In addition to ensuring that medical records can be accessed to protect patient safety, H.R. 3545 also emphasizes that patient privacy is paramount. The bill maintains existing protections against the use of substance use disorder records for any purposes—including criminal proceedings or investigations—outside of treatment, payment, and operations.

H.R. 3545 Must Apply to Payment and Operations, as Well as Treatment

AHIP is a member of a broad-based, multi-stakeholder coalition, the Partnership to Amend 42 CFR Part 2, which is working to build support for H.R. 3545. The Partnership recently addressed a letter to committee leaders, expressing support for this legislation.[4] Our letter stresses the importance of aligning the 42 CFR Part 2 regulations with HIPAA not only for purposes of health care treatment—but also for payment and operations.

We explain: "Ready access to treatment and efficient payment for health care are essential to the effective operation of our health care system. Additionally, certain health care operations, such as administrative, financial, and quality improvement activities, are essential to support treatment and payment. Aligning Part 2 with HIPAA for purposes of treatment alone would not allow for care coordination, payment to providers, or fraud and abuse detection without an authorization."

[4] Letter from the Partnership to Amend 42 CFR Part 2 to House Energy and Commerce Committee Chairman Greg Walden and Ranking Member Frank Pallone. April 23, 2018.

To fully appreciate the importance of applying the bill to treatment, payment and operations, we emphasize that health plans offer significant supports to their network providers to support their patients. Health plan case management programs, and longer-term data collection, are important components of a person's SUD history and support for them and their family when they are not directly engaged in a program. These initiatives will be jeopardized if payment and operations are not aligned with HIPAA.

Below are several examples of how patient data are used for operations:

- Conducting quality assessment and improvement activities (for example, a treatment center may use a patient's information to develop ways to help its physicians and staff decide on the most effective treatment options or improve documentation);

- Conducting population-based analyses and interventions relating to the improvement of health or the reduction of health care costs (for example, a treatment center may use patients' information to identify ancillary information or community services that would assist the patient with favorable outcomes);

- Reviewing the competence or qualifications of health care professionals and evaluating their performance;

- Conducting training programs in which students, trainees, or practitioners learn, under supervision, to practice or improve their skills;

- Conducting training of non-health care professionals (for example, utilizing patient information to show technician staff how to identify risk areas during night shift bed checks); and

- Conducting accreditation, certification, licensing, or credentialing activities (for example, providing information to a health department licensing official as a part of a licensing audit).

Barriers to Effective Treatment and Coordinated Systems of Care for Patients

Unless H.R. 3545 is approved by Congress, current federal regulations (42 CFR Part 2) will continue to pose significant barriers to the protection of patient safety and the coordination of

care for patients who are suffering from addiction. Below we discuss several examples of how the integration of primary care and behavioral health is undermined by existing restrictions on the efficient flow of clinical information to health care providers.

Care Coordination Between Providers: Consider a situation in which a patient recently has been treated at a substance use treatment center and prescribed a medication assisted treatment (MAT) regimen. When the patient visits a health care provider outside of that treatment center, the health plan or treatment center would have to meet strict patient consent requirements in order to share any patient records related to the treatment regimen. The treating clinician will not have access to the patient's complete health record in situations where, for example, the patient is not asked for consent, or is not able to provide consent, such as in an emergency. This can easily result in a clinician prescribing an opioid for a patient on a MAT regimen or other medications or treatments that may conflict with MAT or otherwise cause patient harm. This results in a significant risk to the patient for an opioid relapse and/or adverse events, and hinders safe, effective treatment from both the substance use treatment center and any subsequent providers.

Care Coordination Between New/Subsequent Behavioral Health Organizations or Care Providers: A new treating provider at a substance use facility where a health plan enrollee is treated may contact the health plan to discuss the treatment plan and the appropriate level of care. The health plan may only share information if that provider is specifically listed on the patient's consent form, which may not be the case if the patient is visiting a new treatment center or if there is a turnover of behavioral health care providers. Such information sharing would help to determine the safest and most appropriate treatment plan for the patient, including information regarding a specific treatment modality that an individual has tried or prior treatment at a specific location or level of care. The inability of health plans to provide this level of detail to a new treating provider can result in ineffective and potentially adverse treatment for the patient.

Population Health Data Systems to Improve Care Delivery: Many managed care entities are utilizing comprehensive medical and pharmacy data to inform providers about the care their patients are receiving, help determine accurate diagnoses, develop and coordinate treatment plans, provide member clinical summaries, and identify gaps in care. These efforts are intended to promote timely engagement and improve care delivery and coordination for patients. The current Part 2 regulatory requirements, which require consent mechanisms to be obtained for each treating provider, inhibit the accuracy and effectiveness of these tools and lead to substance use and addiction data being omitted from these sophisticated data systems. This is a significant barrier to integration between primary and behavioral health care.

Implications for Other Opioid-Related Legislation

Finally, we want to emphasize that the success of other opioid-related legislative proposals depends directly on the ability of health care providers and organizations to have appropriate access to a patient's entire medical record (including addiction-related information). This is true for several bills before the committee, including proposals that would:

- **Promote the testing of incentive payments for behavioral health providers for the adoption and use of certified electronic health record (EHR) technology (H.R. 3331).** While we support the adoption of such records for all providers to help integrate care, reduce duplication, and inform appropriate treatment, the increased use of EHRs will be of little benefit for patients seeking treatment for addiction from these providers as those records, under the existing 42 CFR Part 2 regulation, must be siloed and hidden from any provider who does not have the appropriate consent.

- **Establish a demonstration project for an Alternative Payment Model (APM) for treating substance use disorder, including the development of measures to evaluate the quality and outcomes of treatment.** As we stated previously, 42 CFR Part 2 poses a significant barrier for care coordination. Adequate numbers of individuals are needed to make such an investment feasible, and providers may not be able to enroll an adequate number of patients.

- **Instruct the Centers for Medicare & Medicaid Services (CMS) to evaluate the utilization of telehealth services in treating opioid use disorder.** While we support the use of telehealth services to meet behavioral health needs, care coordination is a fundamental aspect of this type of treatment being successful. Absent reforms to 42 CFR Part 2, the benefit of the expansion of such technology will be limited in meeting the demands of the crisis at hand.

- **Require HHS to develop and disseminate best practices regarding the prominent display of substance use disorder history in patient records of patients who have previously provided this information to a health care provider (H.R. 5009).** While we support efforts to prominently display SUD information in patient EHRs, this will be of limited use or effectiveness without reforms to 42 CFR Part 2.

Conclusion

Thank you for considering our views on this important issue. We believe now is the time to modernize 42 CFR Part 2 to align with HIPAA to help ensure that people receive safe, coordinated, whole-person care. We look forward to continuing to work with committee members to improve patient safety, quality, and care coordination for individuals with substance use disorders and to address broader concerns surrounding the ongoing opioid crisis.