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Appendix of Recommendations to The President's Commission on Combating Drug Addiction and the Opioid Crisis

Fully enforce the Mental Health Parity and Addiction Equity Act (the Federal Parity Law or MHPAEA). Full implementation of the Federal Parity Law will increase access to lifesaving treatment. Most Americans are enrolled in health insurance coverage required to comply with the Federal Parity Law. Unfortunately, many of these plans are not compliant. Collectively individuals and small business owners pay billions of dollars for health insurance annually. Enforcement will dictate payors receive what they are legally entitled to.

We need robust enforcement of the Federal Parity Law by the state and federal agencies responsible for implementing the law. This must involve parity-focused market conduct examinations by state insurance departments using first-rate auditing tools.

If state insurance departments refuse to enforce the law, state attorneys general must intervene. New York Attorney General Eric Schneiderman has been successful and other states would be wise to emulate New York's leadership.

We must prioritize private market solutions to secure parity compliance, which can supplement government enforcement activities. This includes educational efforts, accreditation programs and private auditing solutions.

Action Items:

- Direct the US Department of Labor, state insurance commissioners, and attorneys general to investigate parity complaints, and to conduct compliance audits and market conduct surveys using specific audit tools.
- Develop a nationally standardized approach to filing appeals.
- Encourage private sector adoption of parity accreditation programs, auditing standards and related activities.

Implement universal screening and early intervention for substance use and mental illness. All health care professionals should screen for substance use and

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mental health across the spectrum of care delivery settings: primary care, emergency departments, and community-based clinics.
For example, the CAGE AID assessment tool is a widely-used and validated tool for screening substance use disorders. Any screening approach must follow the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model so those in need are identified and promptly receive treatment.

Neglecting to identify and treat a mental health condition in someone battling addiction makes sustained recovery unlikely. The Kennedy Forum has published a helpful issue brief on mental health screening protocols.[1]

Ninety percent of those who become addicted to alcohol or other drugs begin use during adolescence. Despite this fact, too many of our communities simply are not implementing evidence-based prevention practices among our youth. We have known for many years, and the CDC/Kaiser Adverse Childhood Experiences (ACE) Study has confirmed conclusively that when children are deprived of the critical nurturing support needed for healthy development because of living in a chronically traumatized family focused on addiction, their life trajectory is potentially fraught with mental and physical health problems, as well as being set up to continue the costly generational transmission of addiction and of the family trauma that grows from it. We know the healing strategies that caring adults can offer to help these children thrive even when their parents do not get well. Stopping the generational transmission of addiction and starting the transmission of recovery through the generations is essential to eliminating this epidemic. We cannot ignore children in need, who suffer in confusion, fear and silence.

Action items:

- Implement evidence-based screening tools to help identify, diagnose, and treat individuals affected by addiction and mental illness.

[1] http://thekennedyforum-dot-org.s3.amazonaws.com/documents/MBC_supplement.pdf

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- Adopt payment models to promote screening for mental health and substance use in primary care settings.
- Adopt payment models for universal screening for other chronic conditions for all patients with mental illness and substance use.
- Within the education system, implement evidence-based screening tools to help identify, diagnose, and treat students affected by addiction and mental illness starting at the pre-school level and continuing through college years.
- Create mental health systems within our public schools to work in tandem with community mental health professionals and researchers, with the goals of (1) increasing the likelihood of identification of students' mental health needs at earlier stages, (2) provide a pathway to develop innovative prevention and intervention programs, (3) create an integrative system of care in which students have access to the level of treatment needed when needed, and (4) build capacity to sustain mental health services.

Fund supportive services. Funding community-based resources with an evidence-based approach is essential. Proper treatment at a licensed medical facility with a wide array of local supportive services is the best model for sustained recovery.

Action items:

- Expand recovery community centers as specified in the Comprehensive Addiction and Recovery Act of 2016 (CARA)
- Expand other supportive services such as supportive housing, job training, community integration, skill training, peer support services, education services, and 12-step meetings.

Use emergency services as the gateway to real treatment. Many individuals addicted to opioids fall into a vicious cycle of repeated overdose To break this cycle, in some states (such as New York[2]), individuals incapacitated due to substance use and/or alcohol may be held for emergency treatment for up to 72 hours, until they can be stabilized and connected to longer-term substance use disorder treatment options.

[2] https://www.nysenate.gov/legislation/bills/2015/S8137.

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Action items:[3]

- Encourage states to adopt or utilize existing laws so families and first responders can initiate 72-hour emergency treatment for persons incapacitated due to substance use or alcohol (including those to whom naloxone has been administered after an overdose).
- Require 72-hour emergency treatment for persons incapacitated due to substance use or alcohol to contain evidence-based protocols for initiating MAT and "warm handoffs" to treatment and supportive services.

Expand Medication-Assisted Treatment (MAT). MAT is one of the most effective ways to combat opioid addiction.[4] The three FDA-approved medications for MAT are buprenorphine/naloxone, methadone, and naltrexone. Numerous research studies show that MAT saves lives, lowers recidivism rates, and reduces the spread of infectious diseases like HIV and Hepatitis C. Research shows we save $38 for every $1 spent on methadone maintenance thanks to reduced unemployment, lower criminal activity, lower health care utilization, and increased productivity at work.

Unfortunately, the number of health care providers with DATA 2000 waivers[5] for prescribing these drugs is woefully inadequate, and health plans are rationing care by imposing restrictions such as prior authorization. These barriers are directly leading to deaths by limiting access to highly effective medications, especially for those in rural areas who are many miles from the nearest authorized prescriber.

Action items:

- Immediately require all health insurers, Medicare and Medicaid programs and other insurance arrangements to cover MAT drugs, when prescribed by a health care provider with a DATA 2000 waiver, without prior

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[3] The need for balance: http://healthaffairs.org/blog/2016/02/11/expanding-coercive-treatment-is-the-wrong-solution-for-the-opioid-crisis/.

[4] https://www.statnews.com/2017/05/15/medication-assisted-treatment-what-we-know/.

[5] The Drug Addiction Treatment Act of 2000, To receive a waiver to practice opioid dependency treatment with approved buprenorphine medications, a physician must notify the SAMHSA Center for Substance Abuse Treatment (CSAT) of their intent to practice this form of medication-assisted treatment (MAT). The notification of intent must be submitted to CSAT before the initial dispensing or prescribing of opioid treatment. See https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/apply-for-physician-waiver

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authorization. Some companies, such as Cigna and Anthem, have already stepped up to eliminate these kinds of barriers. [6]

- Encourage health insurers to increase their networks of MAT-authorized providers by incentivizing providers to obtain DATA 2000 waivers. We must do this by increasing reimbursement rates, as some insurers have done (e.g., Cigna and New York's Excellus BlueCrossBlueShield[7]).
- Challenge top medical groups like the American Medical Association to require doctors to take the eight-hour online training and apply for DATA 2000 waivers; and for those that are currently authorized, to maximize the number of patients under their care.[8]
- Mandate federally-funded clinics require all physicians, nurse practitioners and physicians' assistants on staff have DATA 2000 waivers (some federally-qualified health centers already do).
- Allow physicians with DATA 2000 waivers to prescribe MAT drugs in underserved areas and across state lines using telemedicine.
- Encourage physicians' assistants and nurse practitioners to obtain DATA 2000 waivers, as is now permitted under the Comprehensive Addiction and Recovery Act (CARA)[9].
- Make it easier for people to find MAT by: (a) fixing the Substance Abuse and Mental Health Services Administration (SAMSHA) MAT provider locater to show accurate, up-to-date listings[10]; and (b) requiring health plans to post current lists of network providers accepting new patients without a waiting list.
- Fund research and require insurance coverage for long-acting implantable forms of MAT.

Promote telemedicine. Telemedicine is an innovative way to provide behavioral health services to those who have limited access to qualified providers. Many rural U.S. counties do not have a single practicing psychiatrist. We also have a severe

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[6] https://ag.ny.gov/press-release/ag-schneiderman-announces-national-settlement-cigna-discontinue-pre-authorization; https://ag.ny.gov/press-release/ag-schneiderman-announces-national-settlement-anthem-discontinue-pre-authorization.
[7] https://aishealth.com/archive/ndbn031513-02.
[8] https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training
[9] https://www.asam.org/education/live-online-cme/buprenorphine-course.
[10] https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator.

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shortage of qualified providers to render addiction services in many communities. Telemedicine can link those in need with no proximate access, to qualified providers.

Unfortunately, many barriers prevent telemedicine from being implemented as widely as it needs to be. For example, the Ryan Haight Act makes it impossible for buprenorphine to be prescribed through the practice of telemedicine without an in-person evaluation occurring first. Yet many rural Americans do not live within 100 miles of a provider who has received a waiver to prescribe buprenorphine. Proximity makes one of the most effective forms of medication for addiction essentially off limits.

Action items:

- Change existing regulatory and licensing barriers that unnecessarily limit the delivery of care through telemedicine.
- Promote successful tele-mental health models developed by federally-qualified health centers and others (such as Western New York, Vermont).
- Encourage adoption of accreditation standards for tele-mental health and tele-addiction treatment.

Promote care coordination. The privacy requirements for medical records of patients with substance use disorders mandated by 42 U.S.C 290dd-2 and further specified in 42 CFR Part 2 were necessary when the law was passed over four decades ago. However, these requirements are now obsolete and create a significant obstacle preventing patients receiving substance use treatment from receiving 21st century care. In the digital era, patients receiving treatment for all other medical conditions can have their medical records updated in real-time and shared amongst all medical professionals who provide them with care. However, 42 CFR Part 2 limits the sharing of any information about treatment of substance use disorders without the written consent of the patient. Written consent is impossible to obtain when someone has overdosed or is in the depths of drug-induced psychosis.

42 CFR Part 2 also unwittingly fuels the opioid epidemic through the provider's inability to access complete medical information. Without the benefit of a

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complete medical record, if someone with substance use disorder sustains an injury, a medical provider or dentist will likely prescribe opioid pain medications. No credible provider would prescribe an opioid to someone with a history of addiction treatment. 42 CFR Part 2 is both a disservice to the patient, and the provider.

Action items:

- Amend federal privacy rules to allow secure sharing of information regarding a patient's treatment for substance use disorder between authorized providers without patient consent.
- Rely on the established protections contained in the Genetic Information Nondiscrimination Act (GINA) to establish safeguards for sharing substance use disorder treatment information.

Increase provider and prescriber accountability. We will never stem the opioid crisis without increased participation and accountability from providers and prescribers. Many providers and prescribers are not using the best evidence-based practices when treating substance use disorder, which means people are not always getting the right care in the right setting. This shortchanges both public and private payers who have a right to expect all behavioral health professionals to provide the best, available and most cost-effective treatments. Providers must use the latest evidence-based practices. Payers can promote the use of such optimal clinical pathways through value-based payment incentives.

Providers must be required to use measurement-based care. Without accountability, we cannot gauge the effectiveness of a particular treatment, or a combination of treatments, procedures, and medications. Incentives should play a leading role in the form of value-based payments and rewarding providers and facilities who yield positive outcomes in a cost-effective manner.

The new Certified Community Behavioral Health Centers created under the bipartisan Excellence in Mental Health Act, should be extended and expanded. Certified Community Behavioral Health Centers are required to offer expanded access to a comprehensive range of mental health and addiction treatment services using evidence-based treatments. They must also implement measurement-based

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care and publicly report their performance outcomes. The centers do receive incentive payments when they exceed outcome expectations.

In addition, we need to implement "transition of care" plans. Individuals admitted to hospital emergency rooms (ERs) for treatment of an opioid overdose are generally stabilized and released without any follow-up care. Instead of acting as a touchpoint on the path to effective treatment, hospital ERs function as a revolving door.[11] Inpatient substance use disorder treatment can help stabilize individuals' physically and mentally while starting them on the road to recovery. Studies show discharging a substance use patient without a continuum of care plan, including supervised aftercare, may be deadly due to the risk of relapse and overdose.[12]

Action items

- Require providers and payers to implement comprehensive "transition of care" and "discharge" plans to ensure proper transitions from facility-based to community-based substance use disorder care and provide the resources to do so (such as what has been done in New York[13]).
- Incentivize value-based care grounded in true outcomes measures such as abstinence and work/school functioning.
- Prohibit payments for referrals to addiction treatment.

Encourage treatment, not incarceration, for nonviolent offenders with substance use disorders. Over the last several years, a consensus has emerged bipartisanly among policymakers: we are not going to arrest our way out of the opioid epidemic. Although traffickers in deadly drugs like fentanyl, carfentanil, and heroin, and doctors who run pill mills, must be prosecuted, their victims – individuals who become addicted to those opioids – should receive help, not jail time, when they commit nonviolent offenses.

Action items:

- Support the work of innovative police initiatives such as the Police Assisted

[11] https://www.acphospitalist.org/archives/2016/03/opioid-overdose.htm.
[12] https://www.ncbi.nlm.nih.gov/pubmed/20022184.
[13] https://www.nysenate.gov/legislation/bills/2015/S8138.

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Addiction and Recovery Initiative (P.A.A.R.I.), which work to quickly divert nonviolent offenders with substance use disorders into treatment.[14]
- Support the work of model drug courts.
- Develop a clear pathway for expungement for individuals demonstrating a commitment to long term recovery.
- Identify community resources to help support those in recovery.

Mandate medical, nursing and other healthcare schools and certification programs to include training for screening mental health and substance use. Universal screening for substance use and mental health is only achievable if we adequately train the next generation of medical professionals. Over 250 people die each day from drug overdoses and suicides, yet most medical students receive no formal training on how to screen for substance use or mental health. All U.S. medical, nursing, and other healthcare schools must mandate behavioral health screening training for every student. Most medical providers, including dentists, lack in-depth knowledge of pain management, which has led to massive overprescribing of opioids. According to NIDA Director Nora Volkow, veterinary students receive five times as many hours focused on pain management as medical students.[15]

Action items:
- Require every U.S. medical, nursing, and other healthcare student, in every discipline, to undergo rigorous behavioral health screening training.
- Require all prescribers to undergo ongoing continuing education regarding pain management (will be required in New York starting July 1, 2017[16]).
- Require all mental health providers, including social workers, master's-level counselors, and psychologists, to undergo rigorous behavioral health screening training.

[14] http://paariusa.org/.
[15] https://www.medpagetoday.com/publichealthpolicy/medicaleducation/56025.
[16] https://www.health.ny.gov/professionals/narcotic/docs/mandatory_education_guidance.pdf.

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Measure employer cost savings from adequate substance use and mental health treatment. The cost to employers due to untreated or undertreated behavioral health conditions among their workers is immense. Employees suffering with substance use, mental illness or both, have much higher rates of absenteeism and presenteeism, meaning they are at work less frequently and perform poorly when at work. Disability payments and worker's compensation claims are often more frequent and costly for those who are not treated adequately, especially those who have co-morbid mental illnesses.

If employers fully assessed the impact of untreated or undertreated drug addiction, such costs would prove a serious drain on their bottom line as compared to the cost of providing access to treatment. Multi-billion dollar corporations that self-fund employees' health care could dramatically improve access to addiction treatment simply by offering more generous treatment coverage through third-party administrators and health plans.

Action items:

- Develop and implement a model for calculating return on investment (ROI) for providing adequate substance use and mental health treatment based on validated criteria (such as ASAM or LOCADTR in New York). This model must include the cost savings from increased productivity, job retraining costs, disability, absenteeism, and other factors.

Utilize Medicaid to save lives. Medicaid has been front and center in addressing this crisis in the states hardest hit such as Kentucky, New Hampshire, Ohio, and West Virginia. The epidemic is disastrous for "red" states and "blue" states alike, and bi-partisan state-level leaders of both parties have stepped up to expand Medicaid coverage to make sure that people get the help they need. Medicaid must continue to protect the most vulnerable in the states currently ravaged by the epidemic and must do so through innovation, coordination of care, and implementation of the most cost-effective, evidence-based practices.

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Unfortunately, a significant barrier is imposed by the Institutions for Mental Disease (IMD) exclusion within Medicaid, which prevents federal reimbursement to inpatient facilities with more than 16 beds that primarily treat individuals between age 22 and age 65 with a substance use disorder or mental health condition. There is no other medical condition for which an exclusion like this exists. While removing the IMD exclusion would raise Medicaid spending, it would lower federal spending in other areas such as law enforcement, criminal justice, juvenile justice, welfare, substance abuse block grants, mental health block grants, unemployment benefits, and dozens of other areas.

Action items:

- Stop the effort to repeal ACA.
- Ensure that persons with substance use disorders have continued access to Medicaid.
- Continue to pursue and implement value-based payment systems for behavioral health service delivery like those created by the Excellence in Mental Health Act, incorporated into the Protecting Access to Medicare Act of 2014.
- Eliminate the IMD exclusion within Medicaid and require the Congressional Budget Office to take into account the many areas for potential federal cost offset when scoring any bill that seeks to amend the IMD exclusion.

Expand prescription drug monitoring programs. Overprescribing of opioid painkillers to patients is a major reason why the U.S. is now battling the opioid epidemic. One reform that has helped reduce the number of pills misused and diverted is the adoption of prescription drug monitoring programs (PDMPs). These programs typically use databases that give prescribers real-time information about their patients' history of receiving scripts for opioids. PDMPs, established in almost every state, have reduced opioid overprescribing and saved lives. However, many states don't obligate prescribers to consult PDMPs resulting in missed opportunities to prevent doctor-shopping to gain access to opioid prescriptions.

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Action items:

- Require every state to adopt a PDMP, and facilitate the development of a national PDMP that all state PDMP can feed into.
- Require all health care providers to check their state (ultimately the national) PDMP before prescribing a controlled substance.

Eliminate the stigma. The days of thinking of addiction or mental illness as a character flaw can no longer be tolerated. Former Surgeons General Dr. David Satcher and Dr. Vivek Murthy have issued authoritative reports establishing mental illnesses and addiction are diseases. The NIH Directors recognize mental illness and addiction as brain diseases.

People affected by substance use and mental illness are simply Americans with a medical condition, not a moral failing. Societally we must recognize these illnesses are brain diseases, and not weaknesses or vices. No one should be ashamed of any medical condition they have.

Action items:

- Secure funding for marketing campaigns to educate the public on substance use and mental illness.
- Fund and develop a national education platform to dispel myths and eliminate the stigma attached to substance use and mental illness.
- Fund and promote training in Mental Health First Aid in schools.
- Promote training in Mental Health First Aid for all Americans.

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