American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

Statement

of the

American Hospital Association

before the

Committee on Energy and Commerce

Subcommittee on Health

of the

U.S. House of Representatives

"IMPROVING THE COORDINATION AND QUALITY OF SUBSTANCE USE DISORDER TREATMENT"

May 8, 2018

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – the American Hospital Association (AHA) thanks you for your leadership in addressing the nation's opioid epidemic. As you continue the effort to craft a comprehensive legislative package in the Energy and Commerce Committee, we reiterate our strong support for legislation that would allow responsible sharing of patient substance use disorder (SUD) treatment information and prevent inappropriate and dangerous prescribing of opioids by amending 42 CFR Part 2 to align with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and health care operations.

Clinicians treating patients for any condition need access to their complete medical histories, including information related to SUD to ensure their patients' safety and delivery of the highest quality care. Partitioning a patient's record to keep SUD diagnoses and treatments hidden from the clinicians entrusted to care for them, as required by 42 CFR Part 2, is dangerous for the patient, problematic for providers and contributes to the stigmatization of mental and behavioral health conditions.

Too many patients with SUD have stories of how a well-intentioned emergency room physician or other clinician nearly prescribed them an opioid or another drug that would have endangered their life or sobriety. Such incidents occur because current law prevents some clinicians from accessing

information on the patient's SUD history and treatment plan unless the patient has given express consent.

Clinicians in our hospitals and health systems must go to extraordinary lengths to comply with the requirements of 42 CFR Part 2. For example, we have heard concerns from obstetricians who specialize in treating pregnant women with SUD diagnoses and other clinicians who treat both the physical and SUD diagnoses of patients. To ensure compliance with 42 CFR, Part 2, these clinicians must maintain two separate computer systems and two separate medical records. This requirement adds burden and expense, but without benefit.

Recent revisions made by the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Part 2 regulations are not a significant improvement over the previous requirements, and do little to eliminate the regulation's barriers that impede the robust sharing of patient information necessary for effective clinical integration and quality improvement. Complete alignment of Part 2 with the HIPAA privacy rule will, therefore, require statutory changes.

Hospitals and clinicians recognize the valuable role that state Prescription Drug Monitoring Programs (PDMPs) can play in addressing the opioid epidemic. In partnership with the federal government, states have invested hundreds of millions of dollars to establish PDMPs and health information exchanges (HIE), which have effectively prevented dangerous drug interactions by permitting providers and pharmacists to access real-time medication histories of their patients. However, 42 CFR Part 2 requires SUD records to remain separate from other medical records and prevents information about medications prescribed as part of SUD treatment from being shared with other providers without the express, written consent of the patient, undermining the benefit of PDMPs. Congress is wisely moving legislation to expand access to medication-assisted treatment, which makes the need to include SUD treatment information in PDMPs more important than ever.

The importance of coordinated care for patients in treatment for SUD cannot be overstated, and 42 CFR Part 2, enacted more than 40 years ago, is a major barrier to such care. Congress must amend this law, which impedes the sharing of critical patient information that is necessary to deliver the most effective and efficient care. Applying the same requirements to all patient information − whether behavioral or medical − would support the appropriate information sharing essential for clinical care coordination and population health improvement, while safeguarding patient information from unwarranted disclosure. The Mullin Amendment in the Nature of a Substitute would achieve these goals. This language would enhance physicians' ability to share vital health information in a timely manner, while protecting patient confidentiality consistent with HIPAA. We strongly urge the full Committee to approve this legislation.