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June 30, 2022

The Honorable Charles E. Schumer  
Majority Leader  
United States Senate  
S-221 The Capitol  
Washington, DC 20510

The Honorable Mitch McConnell  
Minority Leader  
United States Senate  
S-230 The Capitol  
Washington, DC 20510

The Honorable Nancy Pelosi  
Speaker  
House of Representatives  
H-232 The Capitol  
Washington, DC 20515

The Honorable Kevin McCarthy  
Minority Leader  
House of Representatives  
H-204 The Capitol  
Washington, DC 20515

Dear Majority Leader Schumer, Minority Leader McConnell, Speaker Pelosi, and Minority Leader McCarthy:

Western Governors acknowledge and support the vital role of telehealth in improving health care access for our residents. Western states face unique health care challenges, including higher than average suicide rates and a greater prevalence of substance use disorders (SUDs). The ten states with the highest suicide rates in the nation are all located in the West. As these behavioral health conditions grow, increasing access to care is imperative. However, workforce shortages, low population densities, and vast distances between population centers in our states can make it difficult for providers to establish economically sustainable health care practices. Stigma can also prevent individuals from seeking in-person care.

During the COVID-19 pandemic, the federal government loosened restrictions and granted flexibilities to expand telehealth services, resulting in profoundly positive effects on health care access in the West. Telehealth helps address the challenges faced by our states, especially related to behavioral health, and serves as a critical tool to advance access in rural areas and among underserved populations. Expansion of telehealth service is a significant priority for us as we contemplate strategies to increase access to care. This priority is highlighted in Western Governors' Association (WGA) Policy Resolution 2022-07, *Physical and Behavioral Health Care in Western States* (attached).

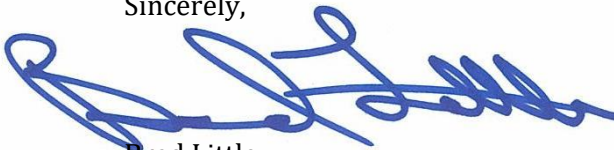
In the resolution, we recognize the importance of this issue and advocate for permanent regulatory and statutory changes based on temporary waivers and authorizations established during the public health emergency (PHE). We note that any changes to federal telehealth policy should ensure that: such changes are driven and informed by patients' needs; patients' choice to receive in-person services is preserved; and only clinically appropriate services are provided via telehealth. We have also held discussions among our states to develop additional bipartisan recommendations for protecting and increasing Americans' long-term access to quality health care services. We urge

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Congress to adopt these recommendations (attached) to promote responsible telehealth use and expansion across the U.S. beyond the PHE.

Thank you for your attention to this matter. Please regard Western Governors as fully invested partners as you consider improvements to our nation's health care system.

Sincerely,



Brad Little  
Governor of Idaho  
Chair, WGA



Jared Polis  
Governor of Colorado  
Vice Chair, WGA

Attachments

## **Telehealth Recommendations**

### **Audio-Only Communication**

Western Governors encourage retention of an option for audio-only communication via telehealth because that option reduces barriers to care, such as a lack of broadband or stigma associated with seeking care. In response to the pandemic, the Centers for Medicare and Medicaid Services (CMS) waived the interactive telecommunications systems requirement of Section 1834(m)(1) of the Social Security Act to permit audio-only visits for certain evaluation and management (E/M) services and behavioral health counseling and educational services. While the CY 2022 Medicare Physician Fee Schedule Final Rule allows some Medicare behavioral health services to be delivered by audio-only telephone calls when video is unavailable, we support legislation to authorize the use of audio-only communication for these and other services.

### **Eligible Providers, Facilities, and Locations**

We maintain that Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) should permanently serve as distant site practitioners to furnish telehealth services. Furthermore, Medicare should reimburse for these services based on payment rates similar to the national average payment rates for comparable telehealth services under the Medicare Physician Fee Schedule. We support legislation to identify FQHCs and RHCs as qualified distant site providers for all telehealth services, beyond provisions in the CY 2022 Medicare Physician Fee Schedule Final Rule that allow FQHCs and RHCs to provide behavioral health services via telehealth. In addition, Western Governors applaud Congress for removing geographic and originating site restrictions for behavioral health services but support legislation to remove these restrictions for other services. Allowing patients to receive telehealth services at locations outside of hospitals and physicians' offices, as well as in all counties (not just those outside metropolitan statistical areas or in Health Professional Shortage Areas (HPSAs)), greatly increases access to care. Originating site flexibility also addresses privacy and stigma concerns related to receiving services in small, rural areas.

The waiver of requirements in section 1834(m)(4)(E) of the Social Security Act and 42 CFR 410.78 (b)(2), which concern the types of practitioners that may bill for Medicare telehealth services from the distant site, expanded the pool of eligible practitioners. Congress should enact legislation to permanently authorize these providers to deliver and bill for telehealth services or otherwise clarify that the Secretary of the Department of Health and Human Services (HHS) can determine which practitioners are eligible to provide telehealth services.

Western Governors are supportive of removing the Medicare requirement that a physician or non-physician practitioner must be licensed in the state in which they are practicing, so long as the providers are also enrolled in Medicaid. The elimination of federal licensing restrictions is especially important to allow health plan members to receive access to specialists who reside outside of their states. Access to out-of-state providers is particularly beneficial for specific needs, such as culturally and linguistically responsive services and behavioral health services. Furthermore, workforce shortages throughout our states may be mitigated by using these providers. We emphasize, however, that states should maintain decision-making authority related to licensing requirements and reciprocity agreements.

## **Prescriptions**

States should also assume authority for telehealth prescription and buprenorphine decisions. As a result of the PHE, practitioners were allowed to prescribe a controlled substance to a patient by telehealth, even if the patient was not at a hospital or a clinic registered with the Drug Enforcement Administration (DEA). Qualifying practitioners were able to prescribe buprenorphine to new and existing patients with opioid use disorder via a telephone evaluation as well. In our states, we observed that these flexibilities were beneficial for people in rural communities, particularly in areas with provider shortages. Flexibility for the provision of buprenorphine treatment for individuals with opioid use disorder during the pandemic has helped to increase utilization of these services as a whole and has increased access for underserved communities. Underserved populations include those with housing challenges, those residing in rural and frontier areas, and those who transition between levels of care and require uninterrupted access to their medications. State control of telehealth prescription flexibility would allow us to exercise discretion based on the individual needs of our states.

Congress should work with DEA and HHS to remove federal requirements related to prescribing substances over telehealth. We recommend that HHS initiate a rulemaking that would revise Substance Abuse and Mental Health Services Administration (SAMHSA) regulations to allow providers to prescribe buprenorphine to patients on a telehealth visit. We encourage DEA to create a special registration program for telehealth providers, as directed by the SUPPORT for Patients and Communities Act, and eliminate the in-person requirement and restrictions on patient location mandated by the Ryan Haight Act.

## **Medicare and Medicaid Telehealth Services**

Agencies can also make regulatory changes that would increase access to care and create an environment more conducive to telehealth. We urge agencies to consider these recommendations and Congress to direct agencies to make these changes, where appropriate. We encourage Medicaid flexibility for states and broad authority for us to utilize telehealth within our Medicaid programs. Under CMS authority, we support the provision of remote patient monitoring services to established patients, for both acute and chronic conditions, and for patients with only one disease. We also support the provision of direct supervision by telehealth, which grants flexibility to rural providers who often contend with difficult winter weather and tight schedules. We recommend that CMS continue to allow annual consent to be obtained at the same time services are furnished as opposed to requiring prior consent. This change has proven beneficial for crisis care and behavioral health engagement.

Additionally, CMS should retain the flexibility that authorizes providers to capture diagnoses affecting risk adjustment during telehealth visits (which is useful for states as they work to address social determinants of health) and permanently remove frequency limitations on certain Medicare services furnished by telehealth. The removal of frequency limitations could provide additional support to rural or swing bed facilities. We support eliminating the requirement that providers must give a physical examination in order to bill for E/M visits. This flexibility promotes health care access for those who are unable to go into a brick-and-mortar provider at least once a year due

to geographic isolation, transportation challenges, or other barriers. We do not, however, support waiving documentation for exams.

We are pleased that CMS, in the CY 2020 Medicare Fee Schedule Final Rule, broadened the list of clinicians that can bill Medicare for virtual check-in, remote evaluation, and e-visit services. We support allowing established patients to receive these services and encourage CMS to allow states flexibility to identify circumstances in which new patients would be eligible to receive these services, as an initial in-person visit could represent a barrier to care in certain situations. We would also like to see physicians and non-physician practitioners be able to provide telehealth visits to nursing home residents beyond the PHE.

During the pandemic, CMS added over 130 new services to its catalog of telehealth services covered by Medicare. We are encouraged that CMS has already made more than 60 telehealth services permanent. These include behavioral health services and certain services for rural patients. We have witnessed dramatic increases in the use of behavioral telehealth services and maintaining access to these services is essential to meeting our residents' needs. We are not, however, supportive of waiving the rulemaking process to make such changes, as coverage often drives other payers' decisions and vetting technologies is critical. We urge CMS to add additional services to Medicare and Medicaid based on federal and state data on outcomes and to consider other means to reduce costs and improve quality of care.

### **Cost Sharing**

HHS's Office of Inspector General (OIG) provided flexibility for health care providers to reduce or waive beneficiary cost sharing, such as coinsurance and deductibles, for telehealth visits paid for by federal health care programs. While we would want to ensure that this provision did not disproportionately increase costs to federal health care programs during the PHE, our states continue to face economic challenges that make it difficult for individuals to pay for health care. Retaining this flexibility would allow patients to make informed decisions about their health without the burden of cost. We advise OIG to consider these economic realities.

### **Accountability and Stewardship**

We recognize that a more widespread use of telehealth may result in an increase of waste, fraud, and abuse, and we acknowledge OIG's efforts to address these concerns by conducting audits for the use of telehealth during the PHE. OIG released a study in 2018 recommending that CMS employ remediation procedures for telehealth like those recommended for claims adjudication for in-person encounters, especially oversight of payments. OIG advised CMS to authorize Medicare contractors to conduct periodic post-payment reviews for telehealth claims and expand education to providers on telehealth requirements. Western Governors believe that this type of evaluation is extremely important and urge CMS to abide by OIG's recommendations.

### **Equity**

Research suggests that access to telehealth (especially video-enabled telehealth) was not equitable across populations during the PHE. The federal government should work with states to facilitate

the deployment of broadband to underserved and rural areas, including HPSAs, recognizing that adequate broadband access has a direct correlation to rural populations' ability to access telehealth and telemedicine. Western Governors are supportive of federal action to leverage and braid funding sources for devices, internet access, and other resources for equitable access to telehealth. We encourage Congress to appropriate sufficient funds in coming years for the Federal Communications Commission's COVID-19 Telehealth Program, which was established by the Coronavirus Aid, Relief, and Economic Security (CARES) Act to help health care providers give connected care services to patients at their homes or elsewhere. Moreover, we would implore CMS to consider how to authorize telehealth supports for medical appointments similar to Non-Emergency Medical Transportation (NEMT), a benefit for those who do not have transportation to appointments. Our states would be interested in providing Medicaid members with these supports to increase access to care.

It is our priority to ensure that telehealth is available to every beneficiary in the West. We are focused on addressing inequities and disparities, improving equitable access to culturally appropriate care, and bolstering the health care workforce. We urge the federal government to work with states in realizing these priorities.

### **Looking Ahead**

Finally, CMS should provide a "runway" of time for conclusion of the PHE so that providers may plan individual transitions for each patient they are serving. This runway should be more than the 60-day notice discussed by CMS to truly allow adequate preparation by the Medicaid agencies, providers, and beneficiaries. When planning for future pandemics, we would like to ensure that flexibilities and waivers that are not made permanent will be readily activated upon a PHE declaration. Such activation will support telehealth services at casualty collection points, alternate care sites, medical shelters, and other medical care sites of opportunity, as well as serve homebound, rural, and marginalized communities. We would appreciate a list of additional temporary flexibilities that can be activated in an emergency.



## Policy Resolution 2022-07

### Physical and Behavioral Health Care in Western States

#### A. BACKGROUND

1. Ensuring access to high-quality, affordable health care is critical to enhancing the quality of life in western states for our growing populations and is the foundation of building and maintaining healthy and vibrant communities and economies.
2. The COVID-19 pandemic illustrated the importance of our health care and public health systems and the urgency with which we must improve health inequities and disparities. Despite warnings of an impending global pandemic, federal, state, local and Tribal governments encountered significant issues containing and responding to the virus, resulting in economic turmoil, supply chain shortages, and a devastating loss of life. In addition, inequities and disparities fueled the spread of COVID-19, affecting many racial and ethnic minority groups who are more likely to live and work in suboptimal conditions.
3. Western states face unique challenges in health care that have been compounded by the pandemic, including growing rates of behavioral health conditions, which encompass mental health and substance use disorders; provider shortages in underserved and rural areas; and limited access to broadband, which has limited the availability of telehealth services. Low population densities and the vast distances between population centers also make it difficult for providers to establish economically sustainable health care practices in rural areas.
4. In addition, distance and density inhibit construction of the technology infrastructure that would provide or improve broadband connectivity in underserved and rural areas. Expanding broadband access provides numerous quality-of-life benefits for rural Americans, including economic development, social connectivity, education, public safety, and access to telehealth and telemedicine.
5. Telehealth utilization has skyrocketed due to the loosening of federal and private insurance restrictions to meet emergency needs during the pandemic. Telehealth is an essential tool to advance health care access, especially in rural areas and among underserved populations, but its use has been limited over the years by federal regulations and licensing barriers.
6. The health care sector faces severe workforce shortages in western states despite efforts of Western Governors, such as the foundation of Western Governors University and other medical training programs in western states, to ensure adequate numbers of qualified medical personnel. This issue has been further exacerbated by COVID-19 and is particularly acute in the West's underserved and rural areas. Ensuring access to health care services requires an adequate number and distribution of physicians, nurses, mental and behavioral health counselors, and other trained health care professionals. Population growth, aging residents, and challenges involving Tribal health care and services for veterans require a renewed focus on developing our nation's health care workforce.

7. Social and economic factors distinct from medical care are powerful predictors of health outcomes and disease burden throughout a person's life. The U.S. Department of Health and Human Services (HHS) defines these social determinants of health (SDOH) as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. It has also identified five key areas of SDOH: economic stability; education; social and community context; health and health care; and neighborhood and built environment.
8. In many cases, SDOH disproportionately affect communities of color and other minority populations in the West and drive disease, worsen health disparities, and present barriers to accessing health care. As such, the integration of health and human services is important to promote a whole person orientation to care that is focused on prevention and is delivered in a culturally and linguistically appropriate manner. Understanding the effect of SDOH on health and health care can inform the development of effective policy to increase access and improve health outcomes for these populations.
9. Western states have a unique body of experience, knowledge, and perspective with respect to health care. The Western Governors' Association (WGA) is ideally situated to collect and disseminate information, including best practices, case studies and policy options, that states can use to improve the foundation for health care services and advocate for shared policy priorities on behalf of their citizens.

### **Behavioral Health Integration**

10. Behavioral health needs are often associated with negative stigma and harmful misperceptions, which can have many detrimental effects, including: a lack of understanding by family members, friends, coworkers, and others; reduced professional, educational, and personal opportunities; various forms of discrimination; and bullying, physical violence, or harassment. Stigma can result in a reluctance to seek help or treatment and contribute to self-doubt and shame associated with behavioral health conditions, including mental health and substance use disorders.
11. Two-thirds of all diagnosable mental illness onset before adulthood, yet the vast majority of adolescents do not receive any treatment. Access to prevention and early intervention services and support for children and youth helps treat behavioral health conditions before they become debilitating and lead to negative outcomes in adulthood.
12. Western states experience higher than average suicide rates. Suicide is the second leading cause of death among youth, and the ten states with the highest suicide rates in the nation are all located in the West.
13. Integrating behavioral and physical health care services and supports can have many positive effects on health outcomes and health care spending. Behavioral health integration presents a more holistic approach to patient care and offers increased access for consumers. Integration can also be an effective tool to de-stigmatize treatment for behavioral health.
14. Substance use disorders (SUDs), including alcohol and drug misuse, are a major public health and safety crisis affecting nearly 21 million Americans. They are particularly prevalent in western states, where individuals are more likely to experience SUDs or have a family member who has. SUDs cross all social and economic lines and tragically take the



lives of tens of thousands of Americans every year. Much attention has been focused on opioid use, and recent federal investment has prioritized opioid prevention and treatment. In western states, however, methamphetamine overdose deaths outpace those resulting from opioid use. It is important to recognize that SUDs encompass all drug classes and polysubstance misuse, and to balance federal SUD investments accordingly. While state and federal progress has been made to address SUDs, additional efforts are necessary to help bridge prevention, treatment, and recovery gaps in western states.

15. Jails and prisons have become de facto behavioral health treatment facilities, which are unequipped to provide needed care. This reality results in inefficient use of public resources and poor outcomes for patients. Youth experiencing a first episode of psychosis are too often sent to juvenile halls, and adults with mental illness and SUD become incarcerated without proper treatment for their underlying chronic behavioral health conditions.
16. Many people experiencing homelessness also struggle with a behavioral health condition, which contributes to the risk of being unhoused. Both supportive housing and adequate, coordinated health and social services must be available to prevent and reduce homelessness for people with mental health and SUDs.
17. The quality and completeness of patient records is an important element of care coordination and patient safety. Ensuring the protection and privacy of these records is a critical aspect of maintaining patient confidence in the health care system and ensuring that patients are forthcoming about their behavioral health needs.
18. Currently, federal privacy rules prohibit SUD treatment providers from fully participating in health information exchanges. This may leave health care providers without a full understanding of a patient's medical history and use of medications, which can reduce the quality of care and lead to negative patient outcomes, including potentially deadly medication interactions.
19. Electronic health records (EHR), state Prescription Drug Monitoring Programs (PDMP), and Health Information Exchange (HIE) are important tools in improving care coordination and addressing the opioid crisis, allowing prescribers and pharmacies to help prevent opioid misuse. At present, there are instances of limited interoperability between EHRs and PDMPs that reduce the potential positive effect of these tools on patient safety. Robust systems for HIE can help to address these shortfalls.
20. Current federal statute limits the ability of state Medicaid programs to cover inpatient and residential treatment and recovery services at facilities with more than 16 beds, also known as the Institutions for Mental Diseases (IMD) exclusion. This antiquated limitation prevents many adults with behavioral health needs from receiving adequate treatment in a licensed health care facility. Waivers for this exclusion offered by the U.S. Department of Health and Human Services (HHS) have provided states with important flexibility and improved access to treatment for patients with SUD, but barriers still remain.
21. Medication-assisted treatment (MAT), including opioid treatment programs, combines behavioral treatment and recovery services with medications to treat SUDs. While MAT has been proven to improve health outcomes and reduce mortality among opioid addiction patients, stigma and myths surrounding the use of MAT limit its potential use in SUD treatment and recovery.

22. The passage of the SUPPORT for Patients and Communities Act in 2018 was a significant step forward for MAT, including by promoting greater flexibility in its use and expanding access to and coverage for MAT. However, significant limits remain on MAT use and providers' ability to take full advantage of these treatment methods.
23. Support from individuals with lived experience, peer support groups, and community-based organizations, including faith-based and cultural organizations, are important components of effective treatment and recovery for SUD and other behavioral health conditions.

**B. GOVERNORS' POLICY STATEMENT**

1. Federal efforts to address health care workforce and access needs should reflect early, meaningful, and substantive input from Governors, who are best positioned to assess the needs of their states and help develop solutions to meet these needs. State-federal collaboration and coordination are integral to addressing these health care challenges. Wherever possible, and where appropriate, the federal government should respect state authority and maximize flexibility granted to states and Governors.
2. The federal government should work with states to facilitate the deployment of broadband to underserved and rural areas, recognizing that adequate broadband access has a direct correlation to rural populations' ability to access telehealth and telemedicine.
3. Western Governors urge the federal government to make permanent regulatory changes based on waivers and authorizations granted during the COVID-19 public health crisis to provide flexibility and increase access to telehealth and telerenting. We propose actions to create an environment conducive to the expansion of telehealth beyond the pandemic, including but not limited to permanently changing provisions of 42 CFR and Section 1834(m) of the Social Security Act (SSA) such as:
  - a. Eliminating the requirement for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allowing visits to be conducted, as appropriate, via telehealth options (42 CFR 483.30);
  - b. Waiving interactive telecommunications systems requirements and permitting audio-only visits for certain services (Section 1834(m)(1) of the SSA);
  - c. Removing requirements specifying the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site, which expands the type of practitioner that can provide services through telehealth and allows all practitioners eligible to bill Medicare for services to deliver those services via telehealth (Section 1834(m)(4)(E) of the SSA);
  - d. Making Federally Qualified Health Centers and Rural Health Clinics qualified distant site providers of telehealth services (1834(m) of the SSA);
  - e. Granting clinicians the ability to provide remote patient monitoring services to new and established patients for both acute and chronic disease management and for patients with only one disease condition (1834(m) of the SSA);

- f. Eliminating originating site requirements to allow patients to take visits from their homes (42 CFR 409.46(e)); and
- g. Expanding geographies to include all counties, not just those located outside metropolitan statistical areas or in health professional shortage areas (1834(m) of the SSA).

Any changes to federal telehealth policy should ensure that patient needs are at the center of those changes. Any changes should also ensure that patient choice to receive in-person services is preserved and only clinically appropriate services are provided via telehealth.

4. Despite efforts by Western Governors to address the shortage of qualified health care workers, significant challenges remain. Governors urge the federal government to examine and implement programs to ensure states have an adequate health care workforce – including in primary care, behavioral and oral health as well as other in-demand specialties – that is prepared to serve diverse populations in urban, suburban, and rural communities. Additionally, the federal government should consider funding new types of personnel, such as community health workers or promotores, in order to further extend the health care team and ensure that patients are connected to resources. Understanding that there remain significant disparities in access and treatment for many populations, Governors also support efforts to increase diversity and representation in the health care workforce to improve health outcomes for all.
5. Western Governors recognize the role that social determinants of health (SDOH) have on the health outcomes and well-being of our citizens, and the effect that social determinants – including economic stability, education, social and community context, and neighborhood and built environment – have on an individual’s health status. Western Governors support efforts to identify risks facing high utilizers of health care services, including food insecurity, domestic violence risk, unmet transportation needs, lack of housing and housing instability, utility, and other essential supports and services, and to develop innovative models designed to improve coordination of medical and non-medical services and use of evidence-based interventions. These models can provide valuable information on how meeting non-health needs and addressing other social determinants can improve overall health status and decrease health spending.
6. Western Governors encourage Congress to adopt legislation that would empower states and local governments to address persistent economic and social conditions – like limited access to health care providers, stable housing, reliable transportation, healthy foods, and high-quality education – that often hinder health outcomes. Such legislation would assist states in developing plans to target social determinants that negatively affect health outcomes for western populations.
7. Western Governors acknowledge the importance of improving our nation’s public health preparedness and response systems. The federal government must examine the lessons learned from COVID-19 in collaboration with states and ensure that we have the capability and necessary public health infrastructure investment to effectively confront future public health challenges. We recommend that the federal government clarify pandemic response roles and build operational capacity within the appropriate health-related agencies. The federal government should also consider how to expand our international health surveillance and public health threat detection mechanisms.

## **Behavioral Health Policy**

8. Western Governors believe patients should have the same access to behavioral health care as they have for physical health care, including prevention and early intervention services and supports for chronic conditions like mental illness.
9. Western Governors support efforts to improve the quality and quantity of behavioral health services and supports available to our residents, as these services and supports are essential to reducing suicide rates and treating a range of behavioral health conditions, including mental illness and SUDs.
10. Western Governors recognize and support efforts at the federal, state, and local levels to promote the integration of physical and behavioral health services. The Governors encourage Congress to adopt legislation and the Administration to implement policies that support states' integration efforts and that encourage health care providers to better integrate behavioral and physical health into their practice of care.
11. Western Governors also support innovation within the behavioral health workforce to create new classifications and address gaps in the continuum of care professionals.
12. Western Governors believe the federal government should work toward treating addiction as a chronic illness and work with Western Governors to develop strategies for addressing SUD that work in concert with state efforts and recognize regional variations in SUD patterns.
13. Western Governors believe that the federal government should take steps to increase opportunities for early intervention and law enforcement diversion to prevent entry into the justice system for individuals with behavioral health conditions. That includes providing law enforcement and emergency service providers with the resources and training they need to divert when appropriate and expanding the availability of community reentry programs that provide appropriate treatment for underlying behavioral health conditions that contribute to involvement in the justice system.
14. Western Governors support efforts to increase the availability of transitional and permanent supportive housing with coordinated health and social services to more fully support and sustain recovery for people with behavioral health conditions.
15. Western Governors encourage Congress to pass legislation that aligns federal privacy requirements for SUDs (42 CFR Part 2) with the requirements for all other types of medical conditions under the Health Insurance Portability and Accountability Act (HIPAA) to improve care coordination and reduce stigma for patients with SUD.
16. The exchange of health information is fragmented and often does not occur, limiting the ability of a provider or team of providers to understand the complete needs of a patient and provide whole-of-person care. Western Governors believe the federal government should take steps to support and help sustain states' administration of PDMPs and ensure that EHRs and PDMPs are fully interoperable between states and the federal government, accessible to relevant health care providers, including opioid treatment providers, and include adequate protections for patients from stigmatization and discrimination.

17. Western Governors support legislation to address the so-called Institutions for Mental Diseases (IMD) exclusion to improve access to SUD treatment and recovery services at residential and inpatient facilities with more than 16 beds, as well as to the full continuum of community-based behavioral health care. This policy solution must also improve access to both inpatient and ongoing, recovery-focused treatment in community settings. Until a legislative solution is enacted, the federal government should continue working with states to provide IMD waivers that offer important flexibility and improve access to treatment for patients with SUD. Implementation of these waivers must also occur in connection with expansions of the full community-based continuum of behavioral health care so that consumers receive services in the lowest level of clinically appropriate care in the community whenever possible.
18. Western Governors support legislative action to increase access to MAT for patients with SUD. This includes eliminating the unnecessary and burdensome registration requirements for physicians, physician assistants, and nurse practitioners to obtain a waiver from the Drug Enforcement Administration to treat opioid use disorder with buprenorphine, which would provide health care professionals with additional flexibility to use MAT to treat opioid-related SUD.
19. Western Governors urge the federal government to develop an evidence-based, culturally competent national education and awareness campaign to reduce the stigma associated with mental health and SUDs and encourage individuals to seek help for these health conditions.

**C. GOVERNORS' MANAGEMENT DIRECTIVE**

1. The Governors direct WGA staff to work with congressional committees of jurisdiction, the Executive Branch, and other entities, where appropriate, to achieve the objectives of this resolution.
2. Furthermore, the Governors direct WGA staff to consult with the Staff Advisory Council regarding its efforts to realize the objectives of this resolution and to keep the Governors apprised of its progress in this regard.

*This resolution will expire in December 2024. Western Governors enact new policy resolutions and amend existing resolutions on a semiannual basis. Please consult <http://www.westgov.org/resolutions> for the most current copy of a resolution and a list of all current WGA policy resolutions.*