



ABHW

Association for Behavioral
Health and Wellness

*Advancing benefits and services
in mental health, substance use
and behavior change.*

July 27, 2017

The Honorable Chris Christie, Chair
White House Commission on Combatting Drug Addiction and the Opioid Crisis
P.O. Box 001
Trenton, NJ 08625

Dear Governor Christie:

The Association for Behavioral Health and Wellness (ABHW) thanks you for your leadership as Chair of the White House Commission on Combatting Drug Addiction and the Opioid Crisis (Commission). As a national trade association for payers that manage mental health and addiction insurance benefits, our focus is on the availability, access, and provision of evidence based treatment. ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health to approximately 170 million people in both the public and private sectors.

ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum. One of our organization's, and member companies', top priorities is fighting the opioid crisis. Behavioral Health Organizations (BHOs) serve as experts, collaborators, drivers of the conversations, and providers of solutions.

Our letter outlines the following seven recommendations for the Commission:

1. Aligning 42 CFR Part 2 (Part 2) with the Health Insurance Portability and Accountability Act (HIPAA)
2. Reforming Prescription Drug Monitoring Programs (PDMPs)
3. Easing the Burden on Primary Care Physicians (PCPs) Willing to Prescribe Medication Assisted Treatment (MAT)
4. Requiring Evidence Based Care in Accordance with National Standards
5. Providing Better Access to Telehealth Services
6. Endorsing the Centers for Disease Control and Prevention (CDC) Guideline
7. Protecting Our Ability to Perform Prior Authorization when Appropriate

Aligning 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA)

Part 2, a 1970s regulation, sets requirements limiting the use and disclosure of patients' substance use records from certain substance use treatment programs. This can prohibit payers from sharing this information with the health care providers on the front line caring for patients

suffering from opioid and other substance use disorders. The outdated regulation severely constrains the health care community's efforts to coordinate care for persons with substance use disorders.

Recognizing the need to revise this outmoded law, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a final rule last year that would make improvements to Part 2. We believe these changes are a small step in the right direction toward integrating care (see attached comment letter), but more needs to be done to fully account for the new realities of, and innovations in, health care delivery today. Aligning Part 2 with the treatment, payment, and health care operations (TPO) language in HIPAA through a legislative fix or regulatory guidance via the Supplemental Notice of Proposed Rulemaking to the Part 2 final rule is necessary. We urge the Commission to work with Congress to further ensure that providers and organizations have all the information necessary for safe, effective, high quality treatment and care coordination that addresses all of a patient's health needs.

ABHW leads a coalition of forward-thinking health care organizations committed to improving care delivery and patient outcomes; but without the ability to share substance use disorder records, they are severely limited in their ability to help reduce the skyrocketing number of emergency room visits due to addictions. We hope your Commission will include Part 2 as a priority area. The SAMHSA regulation severely limits abilities of insurers, doctors, hospitals, pharmacists, electronic health record vendors, pharmaceutical companies, and others from assisting in the nation's efforts to eliminate heroin and prescription drug abuse.

Reforming Prescription Drug Monitoring Programs (PDMPs)

ABHW would like to see expanded access to PDMP data to better identify individuals at risk of prescription drug abuse and enable greater coordination across health care entities.

PDMPs collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. The data are used to support states' efforts in education, research, enforcement, and abuse prevention. PDMP data is provided only to entities authorized by state law to access the program, such as health care practitioners, pharmacists, licensing and regulatory boards, law enforcement agencies, state medical examiners or coroners, and research organizations that use de-identified data for analysis and research.

PDMPs are effective tools for states to intervene and prevent fraud, waste, and abuse for controlled substances. If properly implemented with real or recent data, PDMPs can be used to help understand and identify problem prescribers and individuals who are "doctor shopping" for multiple prescriptions. The most effective PDMPs provide real-time data that is easy to interpret and use and require providers to check them before prescribing. A recent *Health Affairs* article showed a 30% reduction in Schedule II opioid prescriptions when providers were mandated to

check their state PDMPs, and this reduction was sustained over time. Despite this success, many states still do not require providers to check their PDMPs before prescribing.

Very few states permit Medicaid managed care organizations (MCOs) and private health plans or pharmacy benefit managers (PBMs) access to PDMP data. If allowed access, these entities could identify patients at risk of overdose or complications because they are seeking prescriptions using multiple providers and paying for them through their insurance or with cash. Additionally, as critical components of an individual's care management, health plans and PBMs should have access to PDMP data so they can have a more complete picture of the use of controlled substances in the community, including cash pay prescriptions, which they would not necessarily have from pharmacy claims. With access to PDMPs, payers can improve clinical decision-making and patient health care and safety; they can also become a strategic partner in preventing and identifying abuse.

Furthermore, PDMPs do not contain methadone data because methadone is viewed as a medical benefit and not a prescription drug benefit. Factoring in methadone data would certainly assist health plans, states, law enforcement, and others to better identify abuse and misuse.

The Commission should instruct each state to have a PDMP which private health plans, Medicaid, Medicare, and PBMs can access; to which prescribers are providing information; and which allows information to be exchanged across state lines. The creation of a national PDMP would address these concerns.

Easing the Burden on Primary Care Physicians (PCPs) Willing to Prescribe Medication Assisted Treatment (MAT)

Through regulation issued on July 8, 2016, the Secretary of Health and Human Services raised the cap on the number of patients being treated with buprenorphine by a practitioner to 275. Because this helps to decrease the barrier that some patients face in finding a provider to treat their opioid addiction, ABHW was supportive of this increase; and we would even recommend lifting the cap entirely. Additionally, we recommend easing the burden on PCPs willing to prescribe MAT, because even though the patient cap has lifted, it is not often reached, as providers are unable or unwilling to take on patients for various reasons. Development of educational resources and additional training, including online, will help make PCPs more comfortable with MAT and with interacting with persons with a substance use disorder. One example is collaborative education programs that include both PCPs and behavioral health experts. Another idea is to provide incentives to encourage PCPs to take care of their own opioid dependent members. Bundled payments might also help with MAT provided by a PCP.

Another major barrier for PCP prescribing is lack of access to consultation with addiction specialists for complications that occur during treatment. To date, integrative care has focused

more on mental health conditions; we should have equal linkages for substance use services. Codes for use and reimbursement of substance use consultation via telephone by addiction medical specialists and financial incentives to create pairing of addiction providers with primary care medical homes could help drive MAT adoption. A common problem is that PCPs are not able to deal with complications such as relapse, or family issues, and financially funded linkages with substance use providers could help address this.

Furthermore, because the Drug Enforcement Agency (DEA) has a current focus on buprenorphine prescribing and dispensing registrants, any physician involved in using buprenorphine in the maintenance or detoxification of patients addicted to opioids is likely to be audited. The focus on audits has an unintended consequence of causing some physicians to reject patients with opioid dependence because of the pressure associated with heightened government surveillance alongside the complexities of treating addiction.

Requiring Evidence Based Care in Accordance with National Standards

The standard of care for opioid use disorder is to treat the disease with a combination of medication and evidence based psychosocial interventions. As such, ABHW suggests creating a mechanism to ensure providers are aware of, and practicing, evidence based care in accordance with national standards, such as the American Society of Addiction Medicine's (ASAM) National Practice Guideline. This guideline was created to provide information on evidence based treatment of opioid use disorder. It addresses all the FDA-approved medications available to treat addiction involving opioid use and opioid overdose in a single document, aiming to help clinicians make evidence-based clinical decisions when prescribing pharmacotherapies to patients with opioid use disorder. Training providers, as needed, in ASAM criteria would help ensure they are providing evidence based care.

Providing Better Access to Telehealth Services

Telehealth has been proven to drive important advancements for our patients, expand access to care, improve health outcomes, reduce the inappropriate use of psychotropic medications, overcome the stigma barrier, and cut costs. Given the rise in the opioid epidemic and the growing shortage of behavioral health providers, the expansion of telehealth is an important option for the Commission to consider.

Many barriers to telehealth exist, and the elimination of such obstacles would improve access to and quality of care for people with addiction. One significant barrier in this space is the Ryan Haight Act, a law designed to combat the rogue internet pharmacies that proliferated in the late 1990s, selling controlled substances online. This law does not allow controlled substances to be delivered, distributed, or dispensed by means of the internet without a valid prescription; and a valid prescription is one that is issued by a practitioner who has conducted at least one face-to-face medical evaluation of the patient. ABHW recommends making necessary changes to this

law to eliminate the requirement of a face-to-face evaluation prior to a telehealth visit in all states.

Additionally, under section 1834(m) of the Social Security Act, Medicare pays for telehealth services when the service is furnished by an eligible practitioner; a patient is located in an originating site; and the originating site is in a rural area. Removing the originating site and geographic restrictions to Medicare reimbursement and increasing the list of eligible providers would provide better access to telehealth services for people with behavioral health needs.

Other barriers include the lack of a federal definition of telehealth and state regulations and licensure issues.

Endorsing the Centers for Disease Control and Prevention (CDC) Guideline

The Centers for Disease Control and Prevention (CDC) said prescriptions for opioids written by health care providers dropped 13.1 percent between 2012 and 2015. This is due, in part, to the fact that doctors are prescribing opioids less often, and the average dose they are prescribing has dropped. However, the CDC has also reported that the length of prescriptions has increased from an average of 13 days in 2006 to 18 days in 2015; and U.S. doctors are still prescribing three times as many opioids as they were in 1999 and three times more than European doctors.

As part of the effort to continue to reduce the amount of opioid prescriptions, we recommend the Commission endorse the recent CDC Guideline for Prescribing Opioids for Chronic Pain. This document provides recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Ensuring that providers are following these guidelines will translate into more appropriate prescribing of chronic pain medication and help to solve the opioid crisis.

Protecting Our Ability to Perform Prior Authorization when Appropriate

Prior authorization is just one of the ways payers ensure patient safety, provide the most appropriate treatment, and achieve optimal patient outcomes. Insurers want to guarantee that that patients' medications and services provided are medically necessary; up-to-date; as economical as possible; not duplicative; and safe, given other medications patients may be taking. Prior authorization also informs insurers of patients' current health status and allows them to plan for adequate follow-up care.

While some ABHW member companies have ended their prior authorization policies for opioid addiction treatment in some states or nationwide, others believe it is still needed in some cases. For example, if a claim is delayed in getting to the health plan or BHO prior authorization becomes a helpful mechanism that alerts the plan and/or BHO that that an individual is on MAT.

ABHW supports the goals of the Commission and is committed to working with the Administration and Congress to help eradicate the opioid epidemic in our country. We would like to request a meeting with the Commission to discuss this issue in more detail; please contact me at greenberg@abhw.org or (202) 449-7660. We look forward to working with you on this important issue.

Sincerely,



Pamela Greenberg

Cc: Opioid Commission Members