



**Association for Behavioral
Health and Wellness**

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

February 16, 2018

The Honorable Orrin Hatch, Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden, Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The Association for Behavioral Health and Wellness (ABHW) is pleased to have the opportunity to respond to the Senate Finance Committee's request for policy recommendations related to addressing the opioid epidemic. ABHW is the leading association working to raise awareness, reduce stigma, and advance federal policy to improve mental health and addiction care. Our members include top regional and national health plans that collectively care for about 175 million people.

ABHW and its member companies are well aware that 115 Americans die every day after overdosing on opioids. ABHW is fully committed to helping defeat the opioid epidemic and supports a continuum of evidence based, person-centered care to treat individuals with an opioid use disorder, including medication assisted treatment (MAT). Our members work to identify and prevent addiction where they can; and where they cannot, they help individuals get treatment so that they can recover and lead full, productive lives in the community.

Recommendations

Question: How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for opioid use disorder (OUD) and other substance use disorders (SUDs) to improve patient outcomes?

Medicare does not currently reimburse for a continuum of behavioral health services. In particular, Medicare does not cover methadone as a treatment for OUD, residential treatment, intensive outpatient programs, and case management. Coverage of these additional services would expand access to OUD treatment and improve the care beneficiaries receive. In addition, Medicare does not reimburse treatment provided by licensed addiction and mental health counselors and marriage and family therapists. Given the dearth of behavioral health providers in our country and the magnitude of the opioid crisis, Medicare recognition of these licensed professionals would increase our treatment capacity. Peer support services are also not reimbursed by Medicare or in every state Medicaid program. Our members have found peers to

be a cost effective, essential component for supporting both treatment engagement and the long-term success of consumers with SUDs. We urge the Committee to request funding for these valuable services.

We also recommend that Medicare cover the broad array of evidence based treatments for OUD. Although Medicare does cover methadone for the treatment of pain, it does not cover methadone for the treatment of OUD. This policy should be changed so that persons being treated for an OUD have options available to them and the most appropriate treatment for the individual can be provided.

It is also important, in both Medicare and Medicaid programs, to consider paying for nontraditional services (see social determinants of health below). These offerings, while not necessarily health care services, help individuals physically get to and stay in treatment. One such service that Medicare could fund in this area is transportation. This would help ensure that Medicare beneficiaries with an OUD arrive at their doctor appointments and continue to receive the medically necessary treatment prescribed for them.

ABHW supports actions to ease the burden on MAT providers. Given the shortage of opioid prescribers, easing the burden will hopefully encourage more providers to use MAT and thus increase access to evidence based medically necessary treatment. Many physical health providers do not feel comfortable delivering MAT. When they receive coaching, in person or via telehealth, they are more willing to treat their patients with MAT. Developing and reimbursing for SUD consultation codes would allow for better education of providers who can then treat OUD.

ABHW thanks Congress for eliminating some of the barriers to telehealth in the Bipartisan Budget Act of 2018. These provisions will help expand access, overcome stigma, and improve health outcomes. We would like to see Congress take an additional step and make needed changes to the Ryan Haight Act so that states do not require a face-to-face evaluation prior to prescribing via telehealth.

In the Medicaid program, as a result of the exclusion on coverage for Institutes for Mental Diseases (IMDs), there are limits on access to needed and appropriate care. Sometimes, these IMDs are the only hospitals available; and without their use, patients often go to EDs instead. ABHW supports eliminating the IMD exclusion, and as an interim step, allowing states waiver authority.

Additionally, low Medicaid reimbursement rates make it challenging for health plans to get the depth and breadth in their provider networks that are needed to successfully treat individuals with OUD. Increasing Medicaid reimbursement levels would help encourage providers to join plan networks.

A final incentive suggestion is to provide financial enticements to treatment facilities with low readmission rates. This would encourage treatment centers to have a comprehensive holistic approach to treating OUD, keep people in recovery, and lower costs.

Question: What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?

42 CFR Part 2 (Part 2), the outdated 1970s federal regulations governing the confidentiality of drug and alcohol treatment and prevention records, sets requirements limiting the use and disclosure of patients' SUD records from federally assisted entities or individuals that hold themselves out as providing, and do provide, alcohol or drug use diagnosis, treatment, or referral for treatment. 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. ABHW members say Part 2 is one of the biggest – if not the biggest – barriers to fighting the opioid crisis.

Obtaining multiple consents from the patient is challenging and obstructs whole-person, integrated approaches to care, which are part of our current health care framework. Part 2 regulations may lead to a doctor treating a patient and writing prescriptions for opioid pain medication for that individual without knowing the person has an opioid use disorder. Without written consent from the patient, ABHW member companies have had cases where the health plan cannot speak to the patient's primary care provider and other specialists about the patient's SUD, even if that provider is prescribing opioids to the patient. For example, one health plan notes that it found over 200 members had been to Emergency Departments (EDs) over seven times in a six-month period of time. The health plan wanted to share this information through an automatic feed to the respective providers so they could take action in helping these members. However, because the information may have included whether or not a member was categorized as having an SUD, the plan was not able to provide the feed. This was especially troubling, since in reviewing the data, the health plan also found that some members were attempting to obtain opioids from several different EDs. Unfortunately, because of Part 2, the health plan was not able to inform the provider that it appeared their patient may be misusing opioids.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released two final rules on Part 2 in the past year. Both rules take small steps to modernize Part 2, but they do not go far enough. Legislative action is also necessary in order to modify Part 2 and bring substance use records into the 21st Century. Aligning Part 2 requirements with those in HIPAA regulation that allow the use and disclosure of patient information for TPO would improve patient care by ensuring that providers and organizations with a direct treatment relationship with a patient have access to his or her complete medical record. Without access to a complete record, providers cannot properly treat the whole person and may, unknowingly, endanger a person's recovery and his or her life.

Harmonization of Part 2 with HIPAA would also increase care coordination and integration among treating providers and other entities in communities across the nation. We support provisions that preclude Part 2 information from being disclosed for non-treatment purposes to law enforcement, employers, landlords, divorce attorneys, or others seeking to use the information against the patient. We do not want consumers to be made vulnerable as a result of seeking treatment for a substance use disorder. However, disclosures of substance use disorder records for treatment, payment, and health care operations must be allowed. Separation of

substance use from the rest of medicine increases the stigma around the disease and hinders patients from receiving safe, effective, high quality substance use treatment and integrated care.

The Protecting Jessica Grubb's Legacy Act, S. 1850, co-sponsored by Senators Shelley Moore Capito (R-WV) and Joe Manchin (D-WV), would align Part 2 with HIPAA for the purposes of TPO and strengthen protections against the use of substance use disorder records in criminal proceedings. We strongly recommend inclusion of this legislation in any opioid package your Committee considers.

Additionally, very few states permit Medicaid managed care organizations (MCOs) and private health plans or pharmacy benefit managers (PBMs) access to prescription drug monitoring program (PDMPs) data. PDMPs can be used to identify individuals at risk of prescription drug misuse and enable greater coordination across health care entities, and we need to ensure these entities have access to this information. Without access to PDMPs, health plans do not know if someone is doctor shopping or choosing to pay out of pocket for medications. 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. If allowed access, these entities could identify patients at risk of overdose or complications and become a strategic partner in preventing and identifying abuse.

We believe each state should have a PDMP which health plans can access; to which prescribers are providing information; and which allows information to be exchanged across state lines. At a minimum, we strongly encourage interstate access to PDMPs, but we also suggest creating a national PDMP. 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.

Question: What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

In recent years, Medicaid and health plans have increasingly recognized the importance that addressing social determinants of health (i.e. housing, community supports, family supports) play in a person's recovery. Addressing these factors leads to improved health outcomes and lower costs. We recommend that Medicare also expand its thinking on what is necessary to treat beneficiaries with an OUD and consider paying for some of the supports mentioned above. More generally, allowing health plans and others some flexibility in services and programs will allow wraparound and other supports to be provided when needed.

Question: What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?

Some residential treatment facilities in Medicaid provide housing for children and parents together so that families are not separated during the recovery process. Though this program is rare, it is successful. Additionally, payment models exist to encourage more in-home treatment

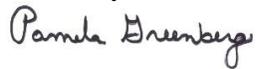
and delivery of MAT in the home. This makes it easier for patients to adhere to their treatment plans.

Additional suggestion:

While not directly related to the questions above, ABHW encourages you to examine the fraud that is occurring in the SUD arena. Lives are being lost at the hands of fraudulent providers, and federal programs are paying for this deadly care. It is critical that state and federal governments crack down on these unlicensed facilities (often times sober homes) that are abusing the health care reimbursement system and taking advantage of people by recruiting them to their facility, bilking payers, and offering substandard – or no – care.

Thank you for the opportunity to provide the Senate Finance Committee with policy recommendations for addressing the opioid crisis. We look forward to continuing this dialogue and working with you to end the overdoses and deaths that are ravaging our country. Please feel free to contact ABHW staff at (202) 449-7660 to discuss these issues further.

Sincerely,



Pamela Greenberg, MPP

President and CEO

Association for Behavioral Health and Wellness