ABHW
Association for Behavioral Health and Wellness
Advancing benefits and services in mental health, substance use and behavior change.

February 21, 2018

The Honorable Richard E. Neal, Ranking Member
House Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr., Ranking Member
House Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Ranking Member Neal and Ranking Member Pallone:

The Association for Behavioral Health and Wellness (ABHW) is pleased to have the opportunity to respond to your letter on opioid use disorders (OUD) in the Medicare population. 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 the Medicare population has high and growing rates of diagnosed OUD. ABHW is fully committed to helping defeat the opioid epidemic and support a continuum of evidence based, person-centered care to treat individuals with an OUD, 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.

Answers to Questions

2. What types of barriers do you experience to addressing the epidemic in the Medicare population effectively?

a. What gaps exist in Medicare's coverage of treatment for opioid use disorder?

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. 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 substance use disorders (SUDs). We urge the Committees 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.

Additionally, ABHW suggests that Medicare have a holistic approach to the services and programs that are needed for beneficiaries with an OUD to fully recover. This includes examining and addressing social determinants of health (i.e. housing, community supports, family supports). Addressing these factors leads to improved health outcomes and lower costs.

c. *What barriers to patients' access to care (such as out-of-pocket costs or other financial limitations) have you identified in the course of working with beneficiaries who are struggling with opioid use disorders?*

Medicare typically does not pay for nontraditional services, like transportation. While not necessarily health care services, providing transportation to a Medicare beneficiary who can't drive helps the person physically get to and stay in treatment. More generally, allowing Medicare Advantage and others some flexibility in the services and programs they offer will allow wraparound and other innovative supports to be provided when needed.

ABHW thanks Congress for eliminating some of the barriers to telehealth in Medicare 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.

4. How do you engage patients on opioid use and misuse?

a. How do you work with patients who may be at risk for opioid overuse based on their prescriptions?

There are two common tools that ABHW member companies employ to help engage individuals in their treatment for OUD. One is evidence based motivational interviewing (MI). MI is defined as a counseling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes.

The other tool used by our members is the Patient Activation Measure which assesses an individual's knowledge, skill, and confidence for managing his or her own health. Studies have shown that the more activated a person is, the more likely he or she is to engage in positive health behaviors and have better health outcomes. Higher activation is also associated with better care experiences.

Both of these tools help lead to better engagement in, and adherence to, treatment.

5. What strategies do you engage in to coordinate care for individuals with OUD, or who potentially use inappropriate amounts of opioids?

The identification of individuals at risk of opioid dependence is a critical step in helping stop overdose and death. To do this, some ABHW members employ drug utilization review (DUR) programs. These programs flag members who are being treated for opioid dependence but are still filling opioid prescriptions (a good indicator that the person may relapse). DUR programs also help reduce the risk of overdose or complications by notifying a pharmacist when individuals are also filling opioid prescriptions at another pharmacy or have prescriptions for other drugs that may have a counter interaction with their opioids. Other companies analyze claims data across both pharmacy and medical benefits to detect opioid use patterns that suggest possible misuse by individuals and then they reach out to the person, or notify their health care provider, about the situation. Additionally, some members are using their data to better understand trends in opioid usage, track prescribing patterns, and explore the conditions for which opioids are most commonly prescribed.

a. How do you coordinate across the spectrum of different providers and payers to meet patients' health care needs?

ABHW members face challenges in coordinating patient care because of 42 CFR Part 2 (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 SUDs. 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 OUD. 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 a 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 the Health Insurance Portability and

Accountability Act (HIPAA) regulation that allow the use and disclosure of patient information for health care treatment, payment, and operations (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 SUD. However, disclosures of SUD records for TPO 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 Overdose Prevention and Patient Safety Act, H.R. 3545, co-sponsored by Representatives Earl Blumenauer (D-OR) and Markwayne Mullin (R-OK), would align Part 2 with HIPAA for the purposes of TPO and strengthen protections against the use of SUD records in criminal proceedings. We strongly recommend inclusion of this legislation in any opioid package your Committees consider.

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.

Additional Suggestion

While not directly related to any of the questions posed by the letter, 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 comments on these important questions. 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

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President and CEO
Association for Behavioral Health and Wellness