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

March 15, 2018

The Honorable Kevin Brady, Chairman
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

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

The Honorable Peter J. Roskam, Chairman
House Committee on Ways and Means
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin, Ranking Member
House Committee on Ways and Means
Subcommittee on Health
1139E Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady, Chairman Roskam, Ranking Member Neal, and Ranking Member Levin:

The Association for Behavioral Health and Wellness (ABHW) is pleased to have the opportunity to respond to your letter on the opioid crisis within the Medicare program. 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 opioid use disorder (OUD). 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 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.

Our comments focus on the following areas from your letter:

- Prescription Drug Monitoring Programs (PDMPs)
- Tools to Prevent Opioid Abuse
- Prescriber Notification and Education
- Opioid Treatment Programs and Medication Assisted Treatment (MAT)
- Fraud in Opioid Treatment

Overprescribing/Data Tracking: 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 managed care organizations (MCOs), Centers for Medicare and Medicaid Services (CMS), 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.

ABHW supports a requirement that each state have a PDMP which private health plans, Medicare, Medicaid, 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 also address these concerns.

Overprescribing/Data Tracking: Tools to Prevent Opioid Abuse

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.

Communication and Education: Prescriber Notification and Education

ABHW recommends easing the burden on primary care providers (PCPs) willing to prescribe MAT. 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, either in person or via telecommunication. 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 address complications such as relapse or family issues, and financially funded linkages with substance use providers could help eliminate this barrier.

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. Additionally, it would be beneficial to have an online database of opioid quality improvement initiatives by and for medical and behavioral health practices. It would help them determine next steps for improving patient care for chronic pain and substance use disorders.

Treatment: Opioid Treatment Programs and Medication Assisted Treatment

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' substance use disorder (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 Committee considers.

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 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.

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). 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. Addressing these factors leads to improved health outcomes and lower costs.

Given the rise in the opioid epidemic and the growing shortage of behavioral health providers, the expansion of telehealth is an important option to consider. Telehealth has been proven to drive important advancements for patients, expand access to care, improve health outcomes, reduce the inappropriate use of medications, overcome the stigma barrier, and cut costs. ABHW thanks Congress for eliminating some of the barriers to telehealth in Medicare in the Bipartisan Budget Act of 2018.

Many barriers to telehealth remain, and the elimination of such obstacles would improve access and quality of care for people with addiction. We would like to see Congress take an additional step and make needed changes to the Ryan Haight Act. The Ryan Haight Act is a law designed to combat the rogue internet pharmacies selling controlled substances online that proliferated in the late 1990s. 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, in all states where it exists, the requirement of a face-to-face evaluation prior to a telehealth visit.

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,

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Association for Behavioral Health and Wellness