



August 26, 2019

Brenda Destro
Deputy Assistant Secretary
Office of the Assistant Secretary for Planning and Evaluation
Office of Science and Data Policy
Department of Health and Human Services
Attention: EPAEDEA Report Feedback
200 Independence Ave, SW
Room 434E
Washington, DC 20201

Re: Request for Information: Ensuring Patient Access and Effective Drug Enforcement

Dear Deputy Assistant Secretary Destro,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Request for Information: Ensuring Patient Access and Effective Drug Enforcement (RFI). ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health, substance use disorders (SUDs), and other behaviors that impact health and wellness.

ABHW reviewed the RFI and has the following high-level recommendations on how to enhance state prescription drug monitoring programs (PDMPs) and how to fill gaps in pain management and opioid prescribing:

- Allow health plans to 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.

- Align the 42 CFR Part 2 disclosure rules for SUD information with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules for the purposes of treatment, payment, and health care operations (TPO) to allow opioid treatment programs (OTPs) to report methadone and buprenorphine dispensed for the treatment of opioid addiction to a PDMP.
- Expand access to telehealth services to help fill gaps and improve access to pain management and opioid prescribing services.

Our detailed comments on the RFI are as follows:

Access to PDMPs

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, very few states permit Medicaid managed care organizations (MCOs), insurance carriers, or private health plans 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 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 care coordination, clinical decision making, patient health care, and patient safety; they can also become a strategic partner in preventing and identifying abuse.

42 CFR Part 2

Opioid Treatment Programs (OTPs) provide medication-assisted treatment (MAT) for people diagnosed with an opioid-use disorder. A "Dear Colleague" letter issued in 2011 by the Substance Abuse and Mental Health Services Administration (SAMHSA) encourages providers in OTPs to use PDMPs "as an additional resource to maximize safety of patient care," but OTPs cannot disclose patient information to a PDMP because of the current Part 2 requirements.

Part 2 governs confidentiality of SUD patient records, and sets requirements limiting the use and disclosure of patients' substance use records from certain substance use programs. Patients must submit written consent prior to the disclosure of their SUD record. Since PDMPs make information available to authorized users, it "would not be feasible to ensure that the information [submitted by an OTP] will not be redisclosed," according to the SAMSHA letter. Therefore, OTPs are not able to provide PDMPs with data on methadone and buprenorphine dispensed for the treatment of opioid addiction, creating a significant gap in PDMPs data.

We look forward to reviewing the Notice of Proposed Rule Making (NPRM), "Coordinating Care and Information Sharing in the Treatment of Substance Use Disorders," recently released by SAMHSA. We support updating these overly restrictive rules to allow for beneficial enhancements to PDMPs.

Expand Access to Telehealth Services

Expanding access to telehealth services will help to fill in gaps in pain management and opioid prescribing as well as treatment for SUDs. Telehealth services have been proven to drive important advancements for patients, expand access to care, improve health outcomes, reduce inappropriate use of psychotropic medications, overcome the stigma barrier, and reduce costs. Given that approximately 1 in 5 adults have a mental illness and 1 in 12 have a SUD, and the fact that there is a growing shortage of behavioral health providers to respond to this significant need for services, the expansion of telehealth is vital to

help address this growing need for ready and timely access to necessary treatment.

In particular, telebehavioral health care has gained recognition over the past decade as a solution to enhance access to quality behavioral health care in the United States. Telehealth can create an equitable treatment option to those with limited or no access to behavioral health services. Telebehavioral health can improve access, clinical efficacy, coordinated care, and cost-effectiveness. While great legislative and regulatory advancements have been made to eliminate barriers to reimbursement for telehealth, barriers to its use and expansion remain. Some changes that could reduce these barriers include:

- Lessen the barriers created by the Ryan Haight Act that prevent providers from prescribing medicine via telehealth services without a prior face to face visit. There is little evidence to support this policy and it creates a barrier to medically necessary care. Not all people are able to have an initial visit with a provider in person due to behavioral health provider shortages or physical difficulty traveling.
- Expand the list of eligible Medicare providers to include all behavioral health practitioners who are licensed to practice independently. Doing so will not only help increase access to telehealth by growing the pool of available providers, it will also help reduce costs because these providers provide quality, evidence-based care that is oftentimes a less expensive alternative to a doctor's care.

In addition, the Federal Communications Commission (FCC) is proposing significant investment and expansion in telehealth in the NPRM "Promoting Telehealth for Low-Income Consumers." As part of its "Pilot program" set forth in the NPRM, the FCC proposes that the participating programs serve patients in areas designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas or Medically Underserved Areas. While we agree telehealth services are a critical tool to provide patient care in areas with provider shortages, we suggest Health and Human Services work with the FCC to use these designations as only one of the criteria to consider when allocating funding. There are target populations, such as patients with SUD or behavioral health conditions, that do not reside in a designated area who would benefit from participation in a telehealth program. Applicants for funding should be asked to demonstrate that they will serve patients that are currently underserved

(regardless of whether they are in a designated area) or otherwise lack access to critically needed services (e.g., are uninsured or underinsured).

Remove Drug Enforcement Administration Waiver Requirement

ABHW also recommends the removal of the current requirement that providers need a waiver from the Drug Enforcement Administration to prescribe medication-assisted treatments (e.g., buprenorphine). This would broaden MAT access for patients with opioid use disorder. We support the current bills that would remove this requirement: H.R. 2482, Mainstreaming Addiction Act of 2019, and the Senate companion bill, S. 2074.

Thank you for the opportunity to comment on the RFI. Please feel free to contact Kate Romanow, Director of Regulatory Affairs, at romanow@abhw.org or (202) 449-7659 with any questions.

Sincerely,



Pamela Greenberg, MPP
President and CEO