



Advancing Health Care Policy
for Mental Health and Addiction

August 12, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information; Reducing Administrative Burden to Put
Patients over Paperwork (CMS-6082-NC)

Dear Administrator Verma,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Request for Information: Reducing Administrative Burden to Put Patients over Paperwork (RFI). ABHW is the trade association which serves as 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 reduce unnecessary administrative burden and improve patient care:

- Align 42 CFR Part 2 (Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment, and health care operations (TPO) to allow appropriate access to patient information that is essential for providing whole-person care and protecting patient safety, while reducing administrative burden.

- Allow health plans to have access to prescription drug monitoring program 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.
- Continue to allow health plans to require prior authorization on certain services when necessary in order to ensure appropriate patient care.

Our detailed comments on the RFI and these high-level recommendations are as follows:

42 CFR Part 2

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 treatment programs. Patients must submit written consent prior to the disclosure of their SUD information. Obtaining multiple consents from the patient is administratively burdensome, creates barriers to coordinated care, and most importantly, can impede patient treatment and safety.

When a patient's written consent is not available to a provider, Part 2 can create a great administrative burden for providers who have to try to physically locate a patient to obtain that consent. Part 2 also severely constrains the health care community's efforts to coordinate care for patients with a SUD by preventing the ability of plans and providers to share important information with health care practitioners providing treatment to individuals suffering from SUDs. Whole-person, integrated approaches to care have been proven to produce the best outcomes for patients. This lack of integration also affects patient safety. When records cannot be shared, this may result in dangerous drug-drug interactions or a provider writing a prescription for an opioid pain medication for a patient without knowing they have a SUD.

We recommend a new rulemaking process that updates the antiquated Part 2 regulations and aligns it with HIPAA privacy rules for the purposes of TPO to allow for reduced administrative burden, improved integrated care, and enhanced patient safety.

Access to Prescription Drug Monitoring Program Data

Prescription drug monitoring programs (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 clinical decision making, patient health care, and patient safety; they can also become a strategic partner in preventing and identifying abuse. Permitting plans access to PDMP data reduces administrative burden by allowing for more effective care coordination between plans and providers.

Prior Authorization

CMS may receive comments in response to the RFI about curtailing prior authorization for certain medications or treatments in order to lessen provider burden. We request CMS consider the benefits of prior authorization and how its use can ensure safe, effective, and appropriate patient care.

Prior authorization is the process by which a patient, or their provider, obtains approval from a health plan for certain health care services, treatments, or medications before they are received to ensure the clinical appropriateness of the

proposed treatment. Prior authorization is one tool used by health plans to ensure that the treatments and medications provided are the most clinically sound and effective for the patient's specific need. It also provides health plans with the current health status of a patient and allows them to plan for follow up care. In addition, prior authorization can reduce costs by preventing the prescribing of expensive brand name drugs when an appropriate generic is available.

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,

A handwritten signature in cursive script that reads "Pamela Greenberg".

Pamela Greenberg, MPP
President and CEO