



October 31, 2019

James W. Carroll  
Director  
U.S. Office of National Drug Control Policy  
Washington, DC 20503

Re: National Drug Control Strategy

Dear Mr. Carroll,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Office of National Drug Control Policy's (ONDCP's) 2020 National Drug Control Strategy (Strategy).

ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to over 200 million people in both the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

ABHW comments focus on current Strategy implementation measures that we encourage ONDCP to continue making a priority and suggestions on expanding these implementation areas, and another suggested area of priority.

## **Current Strategy Implementation Measures**

### **1. Prevention**

- **Expanding the Use of Prescription Drug Monitoring Programs**

ABHW is in support of ONDCP continuing to focus on expanding the use of prescription drug monitoring programs (PDMPs). One way to expand use of PDMPs is to 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.

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 *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.

- **Enhancing Research and the Development of Evidence-Based Prevention Programs**

We recommend that ONDCP continue to focus on enhancing research and the development of evidence-based prevention programs. ONDCP could also look at the work being done by the National Institute on Drug Abuse (NIDA). NIDA is researching the health effects of drug use and has developed a plan to increase the understanding of the brain as it relates to behavior and translate what is learned into more effective SUD prevention and treatment. Their research strategy could inform or shape ONDCP's Strategy.

## **2. Treatment and Recovery**

- **Eliminating Barriers to Treatment Availability**

ABHW recommends ONDCP continue to place an emphasis on eliminating barriers to SUD treatment availability. ONDCP should include a focus on reducing barriers by expanding access to treatment of SUDs through telehealth. 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. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requires the United States Attorney General to promulgate regulations specifying the limited circumstances in which a special registration for telemedicine may be issued that allows providers to prescribe controlled substances via telemedicine without a face to face visit. However, this special registration would only be allowed if there is a “legitimate need” such as a lack of in-person providers. This limited exception means there are still barriers to telehealth.

- 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.
  - Address state licensure issues to allow providers to deliver telehealth services across state lines. We support common licensure requirements for providing telehealth services in order to allow for healthcare providers to provide such services across state lines.
- **Expanding Access to Peer Recovery Support Services**

ABHW recommends ONDCP continue to focus on expanding access to peer recovery support services. Peer support services are specialized therapeutic interactions conducted by self-identified current or former consumers of behavioral health services who are trained to offer support and assistance to others in their recovery and community reintegration process. These services are an effective component of behavioral health treatment and can be an essential factor in supporting SUD treatment engagement and long-term recovery. One way to expand access would be to require Medicare to provide coverage of peer support services.

- **Reducing Stigma and Making Recovery Possible**

ABHW recommends ONDCP continue working on reducing stigma associated with SUD. In 2014, ABHW launched the [Stamp out Stigma](#) initiative to reduce

the stigma surrounding mental illness and SUDs. It is the goal of Stamp Out Stigma to change perceptions and reduce the stigma of mental illness and SUDs by encouraging people to talk about them.

Despite the prevalence of mental illness and SUDs across all segments of society, individuals living with these conditions often feel isolated and alone. The persistent stigma linked to addiction often keeps people from seeking the help they need. Overcoming stigma is a critical step to helping people access the treatment and support they need to recover and lead healthier, higher-quality lives. ABHW welcomes any opportunity to collaborate with ONDCP to reduce stigma related to SUD.

- **Enhancing Evidence-Based Addiction Treatment**

ABHW recommends that ONDCP continues to place a priority on enhancing evidence-based addiction treatment. Some additional areas of focus could include:

- Quality standards for services provided by MH and SUD treatment programs and providers, which may include licensure, third party oversight and performance evaluations. Adoption of quality measures and standards could be used to promote accountability through certification and/or accreditation programs. The Substance Abuse and Mental Health Services Administration (SAMHSA) includes evidence-based practices and accreditation among their “five signs of quality treatment” and several organizations, including Shatterproof, the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Alliance for Recovery Residences (NARR), and the American Society of Addiction Medicine (ASAM) are involved in these important efforts. These efforts range from developing outcome measures and results-based care models to developing certification and accreditation programs for recovery housing and opioid treatment programs. A stronger quality measurement and accreditation/certification infrastructure for MH/SUD treatment would also make it easier to identify ineffective and/or fraudulent SUD providers.
- Identify and eliminate fraud in the SUD treatment space. As stated above, quality standards would help to identify fraudulent SUD providers. Other areas of focus could include working to eradicate

deceptive advertising by SUD treatment facilities, increased penalties for body brokers (individuals who knowingly and willfully pay or receive kickbacks in return for referring a patient to a recovery home, clinical treatment facility or laboratory) and establishing new oversight structure for recovery/sober homes.

- Processes for educating and supporting physicians on evidence-based protocols and treatment plans for SUD patients.
  - Leverage data analytics to proactively identify patients who may be at risk for SUDs and who could benefit from early intervention.
- **Increasing the Size of the Addiction Service Workforce, and Treatment and Recovery Infrastructure**

We recommend that ONDCP continue to focus on this area. An additional priority in this area could include creating a national standard for training as a SUD counselor (similar to what is the case for registered nurses, doctors, pharmacists and clinical psychologists, etc.). Many states show vast differences regarding their requirements to be certified as an alcohol/SUD counselor. Large portions of the training requirements are based on working experiences (e.g., number of clinical hours in a drug treatment facility) versus adherence to defined best practices. Standardizing certification requirements would help to ensure the patients receive quality SUD treatment from an appropriately trained workforce.

### **Suggested Additional Strategy Implementation Measures**

- **42 CFR Part 2**

ONDCP should also focus on 42 CFR Part 2 (Part 2) to help fight the opioid epidemic. 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 record. Obtaining multiple consents from the patient is administratively burdensome, creates barriers to coordinated care for SUD treatment, and most importantly, can impede patient 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.

Updates to the antiquated Part 2 regulations and better alignment with HIPAA would allow for reduced administrative burden, improved integrated care, and enhanced patient safety. ABHW's comments on the Part 2 notice of proposed rulemaking are available [here](#).

Thank you for the opportunity to comment on ONDCP's Strategy. Please feel free to contact me at [greenberg@abhw.org](mailto:greenberg@abhw.org) or (202) 449-7660 with any questions.

Sincerely,

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

Pamela Greenberg, MPP  
President and CEO