



March 23, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: Request for Information for Coordinating Care from Out-of-State Providers for Medicaid-eligible Children with Medically Complex Conditions [RIN: 0938-ZB57]

Dear Administrator Verma,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Request for Information for Coordinating Care from Out-of-State Providers for Medicaid-eligible Children with Medically Complex Conditions (RFI). Our comments below focus **solely on managed care**.

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.

- I. **Recommendations to enhance the coordination of care for out-of-state children with medically complex conditions:**
  1. ***Align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA).***

The opioid epidemic is one of the most pressing health crises of our time and swift action is needed to ensure that patients who suffer from SUDs are not missing out on vital treatments, especially in a vulnerable population such as children. However, there may be a disruption in services due to the

requirements set by 42 CFR Part 2 (Part 2). Part 2 governs confidentiality of SUD patient records, and sets requirements limiting the use and disclosure of patient substance use records from certain substance use treatment programs. Unlike any other treatment, patients with SUDs must submit written consent prior to disclosure of their SUD record for treatment, payment, and health care operations (TPO), which causes multiple issues.

Part 2 severely constrains the health care community's efforts to coordinate care for patients with SUDs by preventing the ability of plans and providers to share important information with other practitioners providing treatment to these individuals. Whole-person, integrated approaches to care have been proven to produce the best outcomes for patients and this impediment on integration may negatively affect patient safety. Furthermore, Part 2 requirements create an administrative burden on providers to try to physically locate a patient to obtain consent, which is inefficient and ultimately takes time away from patient care.

HIPAA allows providers to freely share information with each other for TPO while protecting the patient's privacy, a feature that would not only increase the quality of care SUD patients receive, but will cut back drastically on the administrative burden for providers. We believe aligning Part 2 requirements with HIPAA, for purposes of TPO, will greatly help in coordinating care for children with SUDs. As such, we urge CMS to first support S. 3374, a recently introduced Senate bill aimed to make information sharing of SUD records easier (while still protecting a patient's privacy), as well as coordinate with Health and Human Services (HHS) to provide regulatory relief for this issue.

## ***2. Health plans should be granted access to prescription drug monitoring programs (PDMPs).***

When coordinating care for out-of-state children with medically complex conditions, it is important to take measures to ensure they do not develop SUDs. One safety mechanism to support the treatment and prevention of SUDs is to allow health plans access to PDMPs. PDMPs collect, monitor, and analyze electronically transmitted prescribing and dispensing data, submitted by pharmacies and dispensing practitioners, which is in turn used to support a state's efforts in education, research, enforcement, and abuse prevention. PDMPs have proven to be 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.

However, access to PDMP data is limited to entities authorized by state law, which generally does not include health plans. If allowed access, health plans could become strategic partners in preventing and identifying abuse by identifying patients at risk of overdose or complications, a key element in coordination of care.

Furthermore, we believe it is crucial to establish a national PDMP so that there is a uniform, consistent database of information available for SUD treatment. Currently, PDMPs are state-specific electronic databases, each with their own requirements and regulations. A national PDMP would be especially prudent when coordinating care across state lines, a central data base would streamline the process and lead to better quality of care for patients.

### ***3. Increase the size of the addiction service workforce and treatment and recovery infrastructure.***

We recommend that CMS allocate resources to the very real problem of workforce shortages, particularly for behavioral health. One option to consider that would help improve the quality of SUD care is to create 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 that patients receive quality SUD treatment from an appropriately trained workforce.

Additionally, with respect to opioid use disorder (OUD), we recommend working with the Drug Enforcement Administration (DEA) to eliminate the practitioner waiver to prescribe buprenorphine for young adults. It is important to remove regulatory hurdles to help reduce unmet needs for addiction treatment. In many areas, ABHW members frequently find it hard to locate a provider willing to provide medication assisted treatment to the consumers they serve. Addressing this barrier would encourage more

providers to prescribe medication for OUD and help individuals overcome addiction.

#### ***4. Support efforts to reduce stigma and make recovery possible.***

Despite the prevalence of mental illness and SUDs across all segments of society, individuals living with these conditions often feel isolated and alone. This may be especially true in a population of children who have medically complex conditions. 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.

To address this issue, ABHW launched the Stamp out Stigma initiative in 2014, to encourage people to talk about mental illness, thus spurring a change in perception and reduction of stigma around mental illness. ABHW welcomes any opportunity to collaborate with CMS to reduce stigma related to SUD.

#### ***5. Utilize telehealth to coordinate treatment for MH and SUDs.***

ABHW is supportive of expanding access to treatment of MH and 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 the growing shortage of behavioral health providers to respond to this significant need for services, expanding 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. In fact, 2015 study shows 67% of teens own a smartphone and spend more than four hours daily engaged with it.<sup>1</sup> Videoconferencing, therefore, is a natural fit for today's youth. Many teens prefer telesessions compared to

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<sup>1</sup> The Common Sense Census: Media Use by Tweens and Teens, [https://www.commonsensemedia.org/sites/default/files/uploads/pdfs/census\\_factsheet\\_teensandsmartphones.pdf](https://www.commonsensemedia.org/sites/default/files/uploads/pdfs/census_factsheet_teensandsmartphones.pdf), last visited Mar 17, 2020.

traditional office sessions because it is familiar and helps build trust. Simply put: Today's youth are more comfortable communicating through a screen.<sup>2</sup>

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.

- 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.

If CMS takes steps to overcome these challenges to telehealth, it will become a vital tool when coordinating care for this unique population.

## **II. Barriers to coordinating care for out-of-state children with medically complex conditions:**

### ***1. Quality of care cannot be certified.***

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<sup>2</sup> Miles, J., Telehealth: Transforming Child Mental Health Care, Nov. 2, 2017. <https://www.nami.org/Blogs/NAMI-Blog/November-2017/Telehealth-Transforming-Child-Mental-Health-Care>, last visited Mar 17, 2020.

ABHW members are committed to individuals receiving excellent care by providers in their networks and have invested significantly in mechanisms to measure and track the quality of care. However, when a person goes to an out-of-network provider that provider is not credentialed by the health plan and the plan cannot certify the quality of that provider. Therefore, ABHW urges CMS to consider measures or mechanisms which would allow health plans to conduct quality reviews of out of network providers so that children with medically complex conditions are receiving the best possible care.

## ***2. Medicaid rates may not be accepted over state lines.***

ABHW members work with state Medicaid agencies to set rates which are unique to a given state. This may become problematic when coordinating care across state lines. For example, if the child is located in State A, is receiving services from a provider in State B, and State B has a higher reimbursement rate, we believe that the provider in State B should be reimbursed at the rates set for State A. Changing reimbursement rates based on which state the provider is located in may cause an administrative burden for health plans because they will need coordinate over state lines with different systems. Any delay or dispute in payment may then potentially lead to a disruption of care for individuals. We request CMS make assurances that the payment rate will always be that of the state where the individual is located.

## ***3. Coordinating care may be an added burden on providers.***

As the healthcare industry is still working towards interoperability, providers may find it difficult to coordinate care for patients. Managed care organizations (MCOs), however, are well suited for the task. Medicaid managed care arrangements, where the state contracts with Medicaid MCOs, provide a variety of services, including administering Medicaid benefits, **arranging and coordinating care and services**, and paying providers. In other words, the managed care model already encompasses coordinating care. In fact, MCOs sought to be included in the definition of “designated provider” in the law<sup>3</sup> so that MCOs may serve as health homes. While MCOs were not specifically named, the law states that “any other entity or provider that is determined by the State and approved by the Secretary” can serve as a health home, which leave MCOs as a viable option. As such, ABHW strongly urges CMS to request that the Secretary of HHS deem MCOs as designated providers so that we may assist in the critical activity of coordinating care.


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<sup>3</sup> Medicaid Services Investment and Accountability Act of 2019, Sec. 3(i)(5).

### **III. Conclusion:**

Thank you for the opportunity to comment on this important RFI. Please feel free to contact Deepti Loharikar, Director of Regulatory Affairs, at [loharikar@abhw.org](mailto:loharikar@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