



April 6, 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: Contract Year 2021 and 2022 Medicare Advantage and Part D  
Proposed Rule (CMS-4190-P)**

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) Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule (proposed rule). Our comments are outlined below.

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, substance use disorders (SUDs), and other behaviors that impact health and wellness.

**Section II(B)(1): The Interdisciplinary Team in the Management of Care**

ABHW strongly believes that coordination of care is vital to delivering high quality care to patients. Section II(B)(1) of the proposed rule requires that each Medicare Advantage organization offering a Special Needs Plan (SNP) must provide each enrollee with an interdisciplinary team in the management

of care that includes a team of providers with demonstrated expertise and training.

As the healthcare industry is still working towards interoperability, providers may find it difficult to coordinate care for patients. Health plans, however, are uniquely situated to help in coordinating care and identifying the interdisciplinary teams needed to address the specific needs of each enrollee. As such, we appreciate CMS acknowledging the strength of health plans to coordinate care and awarding health plans the flexibility to design the services and benefits to meet the identified needs of each patient.

### **Section II(B)(2): Face-to-Face Annual Encounters**

ABHW strongly supports utilizing telehealth in delivering care and is supportive of any movement in that direction. As such, ABHW applauds CMS extending to SNPs the ability to conduct the required annual face-to-face encounter via telehealth, removing the usual mandate for an initial in-person visit. Individuals with mental health and SUDs may not have the ability to appear for a physical appointment before they are referred to a behavioral health provider. Allowing the annual face-to-face encounter (and any subsequent follow-up visits, including for behavioral health) to occur over telehealth may lead to these patients keeping appointments and thereby ensuring they are receiving the care they need.

### **Section II(E): Contracting Standards for Dual Eligible Special Needs Plan (D-SNP) Look-Alikes (Section 422.514)**

ABHW members are committed to enrolling full-benefit dual eligible beneficiaries into D-SNPs that meet new integration requirements. In that regard, we appreciate the flexibility in the proposed rule to implement these requirements in the most appropriate way for each state. However, we believe that the proposed rule's intention to curtail D-SNP look-alikes may disrupt beneficiary services and benefits. As CMS navigates this important issue, we encourage CMS to implement any proposal regarding D-SNP look-alikes with sensitivity towards both continuity of care and the nuances of state requirements as well as market dynamics that might conflict with the

proposed rule. Furthermore, if finalized, we request that CMS delay implementation of this proposed rule by at least one year, if not longer, as it will take plans time to transition and ensure compliance with the new policy.

### **Section III: Implementation of Opioid Provisions in the SUPPORT Act**

As SUDs become more and more prevalent in our society, the healthcare industry must look for innovative ways to help stem the problem. One safety mechanism to support the treatment and prevention of SUDs is to allow health plans access to prescription drug monitoring programs (PDMPs). PDMPs collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners, which in turn is 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-time 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, especially for SUD treatment. Currently, PDMPs are state-specific electronic databases, each with their own requirements and regulations. A national PDMP is 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.

Given the potential to help curb SUDs in our country, we encourage CMS to explore ways where health plans can be given access to PDMPs as well as coordinate with the Office of the National Coordinator for Health Information Technology to establish a national PDMP.

## **Section V(E)(5): Adding, Updating and Removing Measures**

### ***1. Section V(E)(5)(b): Proposed Measure Updates***

We appreciate CMS taking steps to ensure that the Health Outcomes Survey (HOS) remains up-to-date; however, we believe, given the precarious nature of the coronavirus pandemic, now is not the time to make changes to the HOS. Instead, we urge CMS to take into account the significant impact COVID-19 will undoubtedly have on the reliability of HOS results. Beneficiaries are dealing with significant changes to their daily routines and as such, we do not believe a survey should be fielded during this pandemic. Since it is likely the pandemic will be affecting beneficiaries for an extended period of time, we encourage the agency to rate the HOS baseline as “N/A” through 2023.

### ***2. Section V(E)(5)(c): Proposed Measure Additions***

ABHW believes that the new HEDIS measure assessing follow-up care provided after an emergency department visit for patients with multiple chronic conditions is a strong addition to the standards. It is important that the follow-up care for an individual, especially in the realm of behavioral health, be appropriately considered as they can be vital to the patient’s long term well-being.

In addition to this new measure, we urge CMS to provide renewed focus on the issues surrounding 42 CFR Part 2 (Part 2). Part 2 has generally caused a significant disruption in care for patients suffering from SUDs. Part 2, which governs the confidentiality and disclosure parameters for SUD patient records, required the submission of a written consent prior to each disclosure of their SUD record for treatment, payment, and health care operations (TPO).

Part 2 severely constrained the healthcare 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 have negatively affected patient safety.

To address these issues, ABHW leads the Partnership to Amend 42 CFR Part 2 (Partnership). The Partnership is committed to aligning Part 2 with the disclosure requirements under the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of TPO.

On March 27, 2020, the President signed into law the Coronavirus Aid, Relief, and Economic Safety Act (CARES Act). This landmark law includes significant changes to the requirements for Part 2, including requiring a one-time, affirmative, written consent to opt-in to having SUD information used or disclosed for TPO. Information may then be redisclosed in accordance with HIPAA. We believe these changes will greatly help in coordinating care for patients with SUDs. As such, we urge CMS to keep this history in mind and work with HHS when issuing regulations pursuant to the CARES Act.

### **Conclusion**

Thank you for the opportunity to comment on this important proposed rule. 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,



Pamela Greenberg, MPP  
President and CEO