ABHW
Advancing Health Care Policy
for Mental Health and Addiction

December 24, 2020

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
330 C Street SW
Washington, DC 20416

Re: Effective and Innovative Approaches/Best Practices in Health Care in Response to the COVID-19 Pandemic; Request for Information

Dear Secretary Azar,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Effective and Innovative Approaches/Best Practices in Health Care in Response to the COVID-19 Pandemic-Request for Information (RFI). 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 (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

Overall, ABHW is acutely aware of how the pandemic is affecting Americans. Beyond the physical ailments caused by COVID-19, there has been a significant increase in those experiencing issues with MH and SUDs.[1] ABHW is also aware that the pandemic has brought racial inequality and health disparities to the forefront. Our policies moving forward will continue to strive for expanding MH and SUD services, with a focus on equal access and equal quality for those services.

Coordinated, integrated medical and behavioral healthcare improves outcomes and is cost-effective.[2] In the current environment, managed care entities use their experience and expertise to make significant contributions to the growth of integrated healthcare through innovation. ABHW and its members actively work with

[1] Czeisler, M., et al. Mental Health, Substance Use, and Suicidal Ideation during the COVID-19 Pandemic, United States, June 24-30, 2020, Centers for Disease Control, https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm, last visited December 9, 2020.
[2] Croze, Colette. *Healthcare Integration in the Era of the Affordable Care Act*, Association for Behavioral Health and Wellness, July 2015. http://box5595.temp.domains/~abhworg/sample/wp-content/uploads/2019/06/IntegrationPaper-1.pdf, last visited December 9, 2020.

purchasers, other payers, providers, legislators, regulators, and plan members to increase the scope and effectiveness of these innovations and to provide leadership to facilitate collaborative and integrated care. To that end, ABHW members are taking a variety of actions in this area, including supporting and paying for collaborative care codes, conducting studies to determine the value of integration, leading public efforts to educate and encourage plan members to talk to their primary care physicians about mental health, and providing integration toolkits for members to use.

While COVID-19 exacerbated challenges discussed in these comments, these issues existed long before the pandemic. As such, we submit our comments on both best practices and barriers to be considered not only for the duration of the public health emergency (PHE), but after the PHE is lifted as well.

I. Mental Health/Behavioral Health and Substance Use Disorder Innovations/Best Practices

A. 42 CFR Part 2.

At a time when opioid overdoses and deaths are increasing, coupled with the ongoing pandemic, it is essential for both patients and providers that the coordination of care be as simple as possible, without sacrificing patient privacy. Originally, 42 CFR Part 2 (Part 2), which governs the confidentiality and disclosure parameters for SUD patient records, was a barrier to integrated care because it required the submission of a written consent from an individual prior to each disclosure of their SUD record for treatment, payment, and health care operations (TPO). Fortunately, a provision in the Coronavirus Aid, Relief, and Economic Safety Act (CARES Act) aligns Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) so that after initial patient consent, a patient's SUD treatment record can be used or disclosed by a HIPAA covered entity, business associate, or program for the purposes of TPO. The CARES Act not only removes roadblocks to effective patient care, it does so without sacrificing patient privacy.

A new Part 2 regulation must be issued pursuant to the CARES Act by March 2021 and we urge HHS to expedite the regulation to ensure smoother care coordination for those with SUDs.

B. Telehealth Flexibilities.

ABHW supports expanding appropriate telehealth services to improve access, clinical efficacy, coordinated care, and cost-effectiveness. We applaud HHS for expanding telehealth during the PHE and urge you to consider the following:

- ***Geographic and originating site requirements***. ABHW has long supported eliminating the geographic and originating site restrictions so that services can be delivered to patients in their homes or other locations in any area of

the country. There has been resistance to removing these requirements[3] as many believed it would lead to an abuse of services and increase in cost.[4] However, preliminary data collected during the PHE reveals this is not the case.[5] Use of telehealth remained stable, except for mental health services,[6] which underscores an important point. Those with MH or SUDs often times cannot leave their home to go to a specific site to receive care. Allowing these individuals to get the care they need from their homes during the pandemic has helped immensely in staving off lapses in care. As such, we ask HHS to coordinate with Congress to permanently remove these requirements to ensure all Americans have access to timely care.

- ***Cross state licensure*.** ABHW supports and encourages state and federal efforts that foster state licensure reciprocity to improve access through telehealth services. Overall, there is a shortage in behavioral health providers.[7] Telehealth helps to fill this gap, but licensure issues preventing physicians to practice across state lines remain a barrier. We urge HHS to explore ways to make it easier for providers to practice across state lines.

- ***Audio-only telehealth services.*** ABHW supports patient access to audio-only behavioral health services for the duration of the PHE. However, before audio-only services are made permanent, regulatory agencies should conduct research as to whether or not behavioral health services provided via audio-only are an effective long-term strategy to provide quality, evidence-based, and clinically appropriate care. Currently, it is unclear whether audio-only is appropriate for all behavioral health treatments. Specifically, audio-only services for partial hospitalization programs, applied behavioral analyses, psych testing, and group therapy should be evaluated before reimbursed permanently. We urge HHS and other regulatory agencies to assess how to best modify requirements for telephonic modifier codes, quality standards, and protections against potential fraud, waste, and abuse. Ultimately, audio-only behavioral health treatments should have safeguards built around them and should not be a primary or default avenue for care. Post PHE, audio-only should only be used after it has proven to be effective and is deemed to be in the individual's best interest (for example, the patient has limited broadband

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[3] Social Security Act, 42 U.S.C. Section 1834(m).
[4] Taskforce on Telehealth Policy (TTP) Findings and Recommendations, September 2020. https://www.ncqa.org/wp-content/uploads/2020/09/20200914_Taskforce_on_Telehealth_Policy_Final_Report.pdf, last visited on December 9, 2020.
[5] Id.
[6] Id.
[7] National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025, Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf, last visited December 9, 2020.

access and difficulty accessing video technology).

C. Peers.

Peer support specialists are an important part of integrated behavioral health services. They complement therapists, case managers, and physicians as part of a holistic treatment team. Peer support promotes recovery by helping individuals better engage in services, manage physical and mental health conditions, build support systems, and, ultimately, live self-directed lives in their communities.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes peer support as an effective, evidence-based practice. According to SAMHSA, the proven benefits of peer support include reduced hospital admission rates, increased social support and social functioning, and decreased substance use and depression.[8] A 2018 analysis showed that providers with peer services had 2.9 fewer hospitalizations per year and saved an average of $2,138 per Medicaid-enrolled month in Medicaid expenditures.[9] As of January 2017, 43 states allow Medicaid to be billed for peer support services.

During the pandemic, HHS has established that specific non-physician providers, such as licensed clinical social workers, can bill for certain Medicare services,[10] thus recognizing that non-physician providers play a vital role in the health care system. We urge further consideration of peer support specialists in such categories moving forward. The COVID-19 crisis is exacerbating a pre-existing behavioral health workforce shortage, one that is particularly acute in rural areas and minority communities.[11] Peer support services are uniquely positioned to meet these challenges through a workforce that expands access to recovery services in primary care by reflecting the communities to be served and understanding their specific mental health needs.

D. Collaborative Care Model.

Several years ago, HHS approved specific billing codes for the Collaborative Care Model (CoCM), an evidence-based mode of care to deliver MH and SUD services in primary care. CoCM provides for patients to be treated in their primary care office

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[8] Peers Supporting Recovery from Mental Health Conditions, Substance and Mental Health Services Administration, 2017. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf, last visited December 9, 2020.

[9] Bouchery, E., Barna, M., Babalola, E., Friend, D., Brown, J., Blyler, C., Ireys, H., The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization, Psychiatric Services, August 2018.

[10] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 19230 (April 6, 2020),

[11] The Cost and Consequences of Disparities in Behavioral Health Care, February 2018. https://www.ncsl.org/Portals/1/HTML_LargeReports/DisparitiesBehHealth_Final.htm, last visited December 9, 2020.

while pairing that office with a behavioral health care manager. CoCM has proven to be an effective model that integrates care, expands access, and improves outcomes.[12]

Additionally, CoCM makes primary care providers more comfortable with discussing behavioral health issues with their patients, effectively creating a larger workforce capable of treating MH and SUDs. It also allows behavioral health providers to see more patients by practicing at the top of their license. We recommend that HHS explore proposals that would help expand the use and adoption of CoCM.

E. Suicide Prevention.

ABHW members recognize the importance and urgency of suicide prevention. Data shows that suicide rates increased in 49 states between 1999 and 2016[13] and that mental health and substance use disorders can lead to suicide.[14] Unfortunately, only 40% of those suffering from mental illness receive the treatment they need.[15]

Public health experts believe suicide is preventable.[16] To that end, the universally recognizable national number of 9-8-8 as a crisis line for mental health and suicide prevention as proposed by the Federal Communications Commission (FCC) is a strong step towards suicide prevention. However, we believe problems may arise if the FCC does not make a long-term commitment to the crisis line, namely in procuring adequate funding to ensure it remains a viable option for those in need. We ask that HHS promote the use of the crisis line as well as champion its longevity through funding and well-trained personnel.

II. ***Other Topics***: We submit the following as effective strategies to address other critical barriers to care to ensure continuity of operations in a healthcare system.

A. Medication-Assisted Treatment.

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[12] Stergiopoulos, V., et al. The effectiveness of an integrated collaborative care model vs. a shifted outpatient collaborative care model on community functioning, residential stability, and health service use among homeless adults with mental illness: a quasi-experimental study, National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4551376/, last visited December 9, 2020.

[13] Federal Communications Commission, Report on the National Suicide Hotline Improvement Act of 2018, August 14, 2019, pg 1. https://docs.fcc.gov/public/attachments/DOC-359095A1.pdf, last visited December 9, 2020. The report also summarizes that in 2017, more than 1.4 million adults attempted suicide and more than 47,000 people died by suicide. *Id*.

[14] We Can All Prevent Suicide, Substance Abuse and Mental Health Services Administration, https://suicidepreventionlifeline.org/how-we-can-all-prevent-suicide/, last visited December 9, 2020.

[15] Beaton, Thomas. *Employers Could See High Financial Returns for Mental Healthcare*, Health Payer Intelligence, September 13, 2018. https://healthpayerintelligence.com/news/employers-could-see-high-financial-returns-for-mental-healthcare, last visited December 9, 2020.

[16] Centers for Disease Control, *Preventing Suicide: A technical Package of Policy, Programs and Practices*, 2017, pg 10. https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf, last visited December 9, 2020.

Treatment for opioid use disorder (OUD) is most effective with medication-assisted treatment (MAT).[17] However, there are two barriers that severely undermine the full potential of MAT:

- ***Burdensome Evaluation Requirement*:** The Ryan Haight Act, originally passed to combat the rise of rogue online pharmacies, requires an in-person evaluation before a provider can prescribe medication-assisted treatment electronically. However, not all people with SUDs are able to have an initial in-person visit with a provider due to behavioral health provider shortages or physical difficulty traveling. Furthermore, there is little evidence to support this requirement, which ultimately creates a barrier to medically necessary care.

  While the Ryan Haight Act allows for providers to use electronic prescribing without an in-person evaluation when engaged in the "practice of telemedicine," it is nearly impossible to do so. The definition of "practice of telemedicine" includes seven categories in which a provider could meet the in-person requirement through a virtual care platform, including under a special registration granted by the Drug Enforcement Administration (DEA). With the requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, the DEA had until October 24, 2019 to outline rules for providers with a special registration to prescribe controlled substances. That deadline passed without action and the current requirement continues to severely impede those with SUDs from receiving the care they need.

  In light of the COVID-19 pandemic, the DEA has temporarily suspended the requirement for an in-person visit before electronic prescribing can be employed, which has temporarily allowed individuals to safely get the medications they need to treat SUDs. We ask HHS to urge DEA to take the action mandated by Congress to provide a permanent path for providers to treat SUDs via telehealth.

- ***Lack of providers utilizing MAT***: The DEA requires that practitioners apply for a waiver as well as separately register with the DEA in each state where they may prescribe buprenorphine to treat opioid use disorders. This creates a major hurdle to prescribing, as it severely limits the number of providers available to offer MAT. Currently, there is legislation pending, the Mainstreaming Addiction Treatment Act of 2019 (H.R. 2482 and S. 2074), to address this problem by removing the separate DEA registration requirement from the Controlled Substance Act. We urge HHS to work with DEA and Congress to ensure this

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[17] *Id.* The Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services has recently flagged that patients with OUDs may experience difficulty accessing MAT, resulting in under-utilization of an effective treatment. OIG is so concerned about the lack of MAT access that an audit on the utilization of MAT to treat OUDs is currently underway. Office of Inspector General, *Data Snapshot: Medication-Assisted Treatment from Providers Waivered at the Highest Patient-Limit Level*, https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000483.asp, last visited December 9, 2020.

barrier is removed to increase access to MAT.

B. Medicaid Institutions for Mental Disease Exclusion.

People with mental illness and SUDs should have access to a full range of treatment options. Inpatient psychiatric care may be an essential component of that treatment. Under federal law, Medicaid funds cannot be used to pay for services for an adult in an IMD that has more than 16 beds, a provision known as the Medicaid IMD exclusion. This technical requirement causes much confusion in practice. Ultimately, ABHW supports a permanent legislative change to eliminate the IMD exclusion to allow people who rely on Medicaid to have access to MH and SUD treatment delivered in IMDs.

As previously stated, there are ambiguities in the regulation governing the IMD exclusion. For example, per the regulation, states may allow Medicaid managed care organizations (MCOs) to provide up to 15 days of care per month in an IMD "in lieu of" other services covered under the state's Medicaid plan.[18] Some states have interpreted this exception to mean that if 15 days in a month is exceeded, the member loses Medicaid eligibility for that month, which seems to go against guidance.

ABHW members have also experienced differing interpretations about what happens to the managed care capitation payment when a beneficiary exceeds the 15 days. For example, if 15 days is exceeded, is the capitation payment lost for the month, even though the beneficiary remains Medicaid eligible? If a 20-day stay occurs, is the capitation payment to be pro-rated over the month so that 10 days of capitation is permitted? Or, are the first 15 days plus the final 10 days included in the capitation for that month?

So, until the IMD exclusion is fully removed by Congress, we urge HHS to provide additional clarity, perhaps through technical assistance, stakeholder meetings, and frequently asked questions guidance, to reduce confusion and encourage consistent implementation of the exceptions.

C. Electronic Health Records.

To date, many community-based mental health and substance use treatment providers have not adopted electronic health records (EHRs) at the same rate as the rest of the medical system and continue to share information by paper, phone, or fax. This is partly due to a lack of financial incentives. Unliked the rest of the healthcare system, substance use providers are not eligible for financial incentives under the Health Information Technology for Economic Clinical Health Act.[19] The lack of support

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[18] Medicaid Managed Care Final Rule from 2016 (and codified in section 1013 of the SUPPORT Act)
[19] Medicaid and CHIP Payment and Access Commission (2018), Public meeting transcript at pp. 11, https://www.macpac.gov/wp-content/uploads/2017/07/January-2018-Meeting-Transcript.pdf, last visited December 9, 2020.

from incentive programs has led to mental health and substance use treatment providers lagging behind on the adoption of EHRs, ultimately impacting both their ability to integrate care and the quality of care they can provide to their patients.

We propose two areas for HHS to consider to propel EHR adoption among behavioral health providers. First, urge the Centers for Medicare and Medicaid Innovation (CMMI) to, as recommended by Section 6001 of the SUPPORT Act, finance a demonstration furnishing health IT incentive payments to behavioral health providers, including but not limited to, psychiatric hospitals, community mental health centers, and addiction treatment providers. Second, advocate for statutory amendments to Section 6001 to require CMMI to finance the much-needed incentives.

D. Prescription Drug Monitoring Programs.

To successfully coordinate and integrate care, all parties of the healthcare supply chain should be involved, including health plans. One way to integrate health plans into patient care is to expand their access to prescription data monitoring programs (PDMPs).[20]

PDMPs are 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. In fact, 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 health plans access to PDMP data. If allowed, patients seeking prescriptions using multiple providers and paying for them through their insurance, or with cash, could be identified by health plans, thus curbing fraud, waste, and abuse. 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 overall 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. As well as become a strategic partner

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[20] 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.

in preventing and identifying fraud, waste, and abuse. Therefore, we ask that HHS consider ways to encourage states to allow plans to utilize PDMPs to assist with patient care.

III. Conclusion

Thank you for the opportunity to comment on this RFI. ABHW looks forward to being a strong partner on these important issues. Please feel free to contact Deepti Loharikar, Director of Regulatory Affairs, at loharikar@abhw.org or (202) 505-1834 with any questions.

Sincerely,

Pamela Greenberg

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