



January 4, 2021

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: Medicaid Program; Patient Protection and Affordable Care Act; Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information for Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-facilitated Exchanges; Health Information Technology Standards and Implementation Specifications [CMS-9123-P]

Dear Administrator Verma,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the above-referenced Center for Medicare and Medicaid Services' (CMS) proposed rule addressing prior authorization and reducing burden on patients and providers. Our comments, which focus on the request for information on the electronic data exchange of behavioral health information and accelerating the adoption of standards related to social risk data, 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.

While the country is currently grappling with the COVID-19 pandemic, underlying issues of equal access to quality care are becoming an integral part of the analysis for bettering our healthcare system. While the pandemic has simply brought these issues to the forefront of health policy and action, they have long been problematic. ABHW is committed to ensuring that our policies will continue to strive for expanding MH and SUD services, with a focus on equal access and equal quality for those services. As CMS considers these important issues, we urge that meaningful action to address current racial inequality and health disparities be factored into any policy changes.

Section III(B): Electronic Exchange of Behavioral Health Information

Section III(B) of the proposed rule specifically solicits comments to address how CMS can best support electronic data exchange of behavioral health information and how that information can be utilized to treat behavioral health issues. We believe the crux of the solution lies with improving and enhancing the systems for coordination of care, as it is proven that integrating medical and behavioral healthcare improves outcomes and is cost-effective.¹ To successfully coordinate and integrate care, all parties of the healthcare system should be involved, including health plans. We submit the following for CMS' consideration.

A. Electronic Health Records.

As CMS notes in the proposed rule, due to a lack of financial incentives, many community-based substance use and mental health treatment providers have not adopted electronic health records (EHRs) at the same rate as the rest of the medical system. These providers, even with today's technological advances, continue to share information by paper, phone, or fax. Unlike the rest of the healthcare system, substance use and mental health providers are not eligible for financial incentives under the Health Information Technology for Economic Clinical Health Act.² The lack of support from such 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 as well as the quality of care they can provide to their patients.

We propose two areas for CMS to consider to propel broader EHR adoption among mental health and substance use treatment 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 and recommend to Congress that they adopt statutory amendments to Section 6001 requiring CMMI to finance these much-needed incentives.

B. Collaborative Care Model.

Several years ago, CMS 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 while pairing that

¹ Croze, Colette. *Healthcare Integration in the Era of the Affordable Care Act*, Association for Behavioral Health and Wellness, July 2015. Last visited May 27, 2020. <http://box5595.temp.domains/~abhworg/sample/wp-content/uploads/2019/06/IntegrationPaper-1.pdf>

² 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.

office with a behavioral health care manager. Data has proven CoCM to be an effective model that integrates care, expands access, and improves outcomes.³

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. Accordingly, we urge CMS to explore proposals that would help expand the use and adoption of CoCM.

C. 42 CFR Part 2.

At a time when opioid overdoses and deaths are increasing, coupled with the impact of the ongoing pandemic, it is essential for both patients and providers that the coordination of care be as simple and streamlined as possible, while maintaining the highest standards for protection for 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 his or her SUD record – even those for treatment, payment, and health care operations (TPO). Fortunately, a provision in the Coronavirus Aid, Relief, and Economic Safety Act (CARES Act) takes great strides in remedying these issues by promoting partial alignment between Part 2 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules. Though the two privacy frameworks remain distinct, particularly for consent purposes, this alignment paves the way for smoother care coordination without sacrificing patient privacy. Simplifying coordination of care for SUDs to prevent gaps in care and to expand access to care is crucial, especially given that SUDs are on the rise due to the COVID-19 pandemic. It is important to consider that SUDs may continue to rise even after the COVID-19 pandemic (and the accompanying public health emergency) is over, simply from the toll it has taken on Americans.

A new Part 2 regulation must be issued pursuant to the CARES Act by March 2021 and we ask that CMS recognize the urgency of the need for this rule and work with the U.S. Department of Health and Human Services (HHS) to expedite the regulation to ensure smoother care coordination for those with SUDs.

D. Prescription Drug Monitoring Programs.

Successful coordination and integration of care should include the entire spectrum of parties involved in a patient's care, including health plans. One way to integrate health plans into patient care is to aid in the prevention of SUDs by expanding their access to prescription drug monitoring programs (PDMPs).⁴

³ 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.

⁴ 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

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, even though health plans often have a more complete line of sight into patient activity than individual providers. If health plans were allowed to access and use PDMPs, patients seeking prescriptions using multiple providers and paying for them through their insurance, could be more readily identified, thus potentially preventing and treating SUDs as well as 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 is not necessarily apparent 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 in preventing and identifying fraud, waste, and abuse. Therefore, we ask that CMS consider ways to encourage states to allow plans to utilize PDMPs to assist with patient care.

Section III(F): Accelerating the Adoption of Standards Related to Social Risk Data

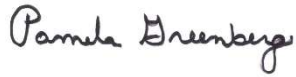
ABHW applauds CMS’ attention to social risk data. As healthcare is becoming more and more integrated, it is clear that there is a need to treat the whole patient, not just individual symptoms. A mental health system that works for the patient and promotes sustained recovery must include social risk data, such as housing status, employment status,, and childcare needs. One way to utilize social risk data is to allow it to be built into rates and included in the numerator of the medical loss ratio calculation, as opposed to categorized as an administrative cost. This would help reflect the true value of social risk data services and ensure patients are receiving the care they need.

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.

Conclusion

Thank you for the opportunity to comment on this proposed rule. Please feel free to contact Deepti Loharikar, Director of Regulatory Affairs, at loharikar@abhw.org or (202) 505-1834 with any questions.

Sincerely,

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

Pamela Greenberg, MPP
President and CEO