ABHW
Advancing Health Care Policy
for Mental Health and Addiction

July 9, 2021

Regina LaBelle
Office of National Drug Control Policy
1800 G Street, NW
Washington, DC 20006

Dear Ms. LaBelle,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to provide input on Office of National Drug Control Policy's (ONDCP) National Drug Control Strategy (Strategy). ABHW appreciates its strong working relationship with ONDCP and looks forward to working closely together on this important Strategy. Our suggestions are below.

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

Overarchingly, our organization's goals aim to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, through our policy work, we strive to promote equal access to quality treatment and address the stark inequities created by systemic racism. We are deeply concerned about health disparities in this country in the areas of MH and SUD services and are committed to addressing systemic racism in the healthcare system. We applaud this Administration's commitment to health equity and look forward to working with you to improve behavioral health services in this country.

Behavioral health services have become increasingly important as a result of social isolation, job loss, illness and death, and domestic violence related to COVID-19; and, we suspect the utilization of such services will continue long after the public health emergency (PHE) is lifted. Addressing the following issues can play a critical role in expanding access to MH and SUD services and provide long lasting improvements to our nation's behavioral health system.

- Align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA)
- Expand the use of telehealth for MH and SUD services
- Increase access to medication-assisted treatment (MAT)
- Support suicide prevention efforts
- Eliminate the Institutions for Mental Diseases (IMD) Medicaid exclusion
- Develop a clear, universal compliance standard related to mental health and addiction parity

- Strengthen and expand the behavioral health workforce
- Ensure health coverage for individuals released from jails and prisons
- Allow access to prescription drug monitoring programs (PDMPs)
- Invest in technological infrastructure
- Reduce fraud and abuse in SUD treatment
- Increase focus on crisis services

As you draft the Strategy, we urge you to consider and include the following:

Issue regulation for 42 CFR Part 2. We look forward to the promulgation of the next 42 CFR Part 2 (Part 2) rule pursuant to the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020. Part 2, which governs the confidentiality of SUD records, sets requirements limiting the use and disclosure of patients' SUD records from certain substance use programs, including the cumbersome requirement of a signed consent by the patient each time the SUD record is to be shared. The CARES Act brings Part 2 into significant alignment with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Changes in the CARES Act permit a patient to provide one written consent to disclose their Part 2 information for all future treatment, payment, and health care operations (TPO), unless the patient revokes consent. Additionally, under the CARES Act, breaches in a Part 2 program trigger patient notification, Part 2 programs are now subject to HIPAA civil and criminal penalties, and discrimination against Part 2 program patients is prohibited. This legislation culminates years of work from a broad range of organizations, and it represents a number of critical compromises.

Attached you will find recommendations from the Partnership to Amend 42 CFR Part 2 (Partnership), which we have previously shared with the U.S. Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as ONDCP. The Partnership, founded by ABHW, brings together a broad spectrum of the healthcare industry to advocate for aligning Part 2 with HIPAA. We urge ONDCP to work with HHS to ensure that the requirements for Part 2 stated in the CARES Act are reflected in the next Part 2 Rule.

Expand the use of telehealth for MH and SUD services. We appreciate the current guidance and flexibilities in response to the PHE and request that the flexibilities continue for at least one year after the PHE is lifted. These long overdue changes to telehealth policies have allowed payers and providers to ensure people can access necessary MH and SUD services in midst of physical distancing. ABHW members support extending flexibilities past the PHE and simultaneously collecting and analyzing data before making permanent changes. As the need for behavioral health services continues to grow, we urge ONDCP to support the following policy changes:

- *Eliminate the new in-person visit requirement for mental health services:* We applaud the recent changes made to remove geographic and originating site restrictions on originating sites for mental health services, allowing beneficiaries across the country to receive virtual care from a location of their choosing. However, these changes were accompanied by a new requirement, mandating that an individual must have an in-person visit with a provider (1) within the six-month period before receiving a mental health service and (2) during subsequent periods as determined by CMS. Given that

many individuals with mental health issues may not physically be able to leave the home at all or without significant assistance, we urge you to support the Telemental Health Care Access Act, H.R. 4058/S.2061), which removes the in-person requirement visit prior to receiving Medicare telehealth services for mental health.

- *Expand cross state licensure:* During the pandemic, all 50 states have used emergency authority to waive certain aspects of state licensure laws, thus providing widespread access to care. We encourage efforts for states to foster cross state licensure reciprocity to support increased access to services. We also propose convening a task force of federal and state leaders to examine this issue and outline recommendations on changes that would increase access to behavioral health services.

- *Examine audio-only telehealth services*. ABHW supports patient access to audio-only behavioral health services for the duration of the PHE and recommends that the appropriate regulatory agencies conduct research to determine how best to leverage audio-only technology as a modality to provide quality, evidence-based and clinically appropriate behavioral health services as a long-term strategy. One way to do this would be to create an audio-only claims coding modifier so that it can be used to track utilization and conduct effectiveness research to differentiate between audio-visual and audio-only services.

  Evaluation of audio-only services would be beneficial to demonstrate quality and efficacy for behavioral health. ABHW advocates that payment for audio-only services to be evaluated in partial hospitalization programs, applied behavioral analyses, psychological testing, and group therapy to ensure that reimbursement is equitable and appropriate. Regulatory agencies should also evaluate quality standards, and protections against potential fraud, waste, and abuse.

Increase access to medication assisted treatment (MAT). Research has shown that MAT is the most effective intervention to treat opioid use disorders (OUDs) as it significantly reduces illicit opioid use compared to nondrug approaches and increased access to MAT can reduce overdose fatalities.[1] As such, ABHW supports the following policy changes to increase MAT access.

- *Eliminate the X-waiver.* During the COVID-19 pandemic, overdoses and related deaths continue to rise, making access to MAT crucial. HHS recently published a Notice which allows providers to treat up to 30 patients using MAT without first obtaining the X-waiver. While this is a step in the right direction to combat OUDs, more must be done. As such, we ask that ONDCP work with Congress to pass the Mainstreaming Addiction Treatment (MAT) Act, S. 445/H.R. 1384. This bipartisan legislation would remove the federal rules established by the DATA 2000 Act that require health care practitioners to obtain a waiver (X-waiver) from the Drug Enforcement Administration (DEA) before prescribing buprenorphine to treat OUDs. The legislation would remove a major hurdle to prescribing MAT, positively impact existing nationwide shortages of treatment providers, and expand access to OUD treatment.

[1] Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder, Pew Fact Sheet, November 22, 2016.

- *Eliminate the in-person evaluation requirement.* Given that not all individuals with SUDs are able to have an initial in-person visit with a provider due to behavioral health provider shortages or physical difficulty traveling, ABHW advocates for actions which would eliminate the in-person evaluation requirement before a provider can utilize MAT via telehealth. The Ryan Haight Act, originally passed to combat the rise of rogue online pharmacies, requires an in-person evaluation before a provider can prescribe MAT using telehealth to treat SUDs. This safeguard likely suppresses the use of MAT because under current law, the evaluation requirement cannot be fulfilled via a telehealth visit.[2] While the Ryan Haight Act allows for providers to use telemedicine when engaged in the "practice of medicine," it is nearly impossible for providers 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 DEA. However, the DEA never created that registration process. With the Special Registration for Telemedicine Act of 2018, which was part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (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, severely impeding those with OUDs from receiving the care they need.

  As such, we recommend that ONDCP urge the DEA to move forward with promulgating the telemedicine special registration process rule, as mandated by federal law, to enable providers to prescribe MAT to patients with SUDs by employing telemedicine.

Support suicide prevention efforts. Congress passed the National Suicide Hotline Designation Act of 2019, making the National Suicide Prevention Lifeline an easy to remember three-digit number, 9-8-8. The need for Americans to have readily available access to mental health crisis services through a ubiquitous number like 9-8-8 is more urgent than ever. We urge ONDCP to work with the Federal Communications Commission (FCC) to ensure the timely implementation of 9-8-8 by July 2022.

In addition to swiftly creating the crisis line, it is equally important that the crisis line have adequate resources so that it can operate effectively and ensure that all Americans can access it. Since demand will undoubtedly increase for services of the crisis line, there will need to be significant investment after the initial implementation to expand capacity and provide services consistently for mental health crises. Therefore, we ask that ONDCP work with Congress to pass H.R. 2981, the Suicide Prevention Lifeline Improvement Act of 2021. This legislation would require increased coordination, data sharing, and provide more funding to support community-based crisis service delivery.

Eliminate the Institutions for Mental Diseases (IMD) Medicaid exclusion. We urge Congress to remove policy barriers that limit beneficiary access to needed and appropriate MH and SUD care. This includes ending the IMD exclusion, which prohibits Medicaid reimbursement for adults under the age of 65 in residential behavioral health facilities with more than 16 beds. Although the IMD exclusion cannot be fully eliminated without Congressional action, the Administration could increase access and improve appropriate care

[2] Kayla R. Bryant, *Health Law Daily Wrap up, Strategic Perspectives: States Fail to Fully Use Telemedicine to Fight the Public Health Crisis,* Wolters Kluwer (September 28, 2018), p.2.

through expanded use and allow for further flexibilities of waivers under section 1115, which would enable states to more broadly cover IMD services. Further, as we have witnessed, national hospital capacity has been pushed to its limits during the COVID-19 pandemic. Waiving the IMD exclusion to Medicaid funding for inpatient behavioral health treatment would free up beds in local hospitals, allowing them to better manage the surge capacity in both inpatient and emergency departments to care for COVID-19 patients.

Develop a clear, universal compliance standard related to mental health and addiction parity. ABHW member companies continue to invest significant time and resources to understand and implement Mental Health Parity and Addiction Equity Act (MHPAEA); Our member companies have teams of dozens of people working diligently to implement and provide MH/SUD parity benefits to their consumers. We have also had numerous meetings with the regulators to help us better comprehend the regulatory guidance and to discuss how plans can operationalize the regulations.

While parity has progressed since its adoption in meaningful ways and access to MH and SUD treatment providers has greatly expanded, systemic issues continue to be a challenge due to other non-parity factors such as the looming shortage of physicians (both psychiatrists as well as other MH and SUD providers). Examples of key changes since the parity law and regulations were enacted include: the fact that routine MH outpatient treatment no longer habitually requires prior authorization or has explicit quantitative treatment limits; evidence-based levels of care for MH conditions are no longer subject to blanket exclusions (e.g., residential treatment for eating disorders); and transparency, documentation, attention to medical necessity criteria all have improved.

However, despite these gains and the parity language in the 21st Century Cures Act, aspects of the law and regulations remain overly complex and technical. As a result, compliance has become a moving target through a patchwork of conflicting and changing guidance. There is new parity language in Section 203 of the recently passed Consolidated Appropriations Act (of 2021 (CAA), and the Department of Labor issued a Frequently Asked Questions (FAQs) document to help clarify the CAA provisions. While the FAQs are a step in the right direction, we believe further regulations are necessary to provide the clarity payers need to appropriately implement MHPAEA. We strongly support the flexibility built into the law, yet there has been a proliferation of different compliance approaches, tools, and interpretations, which continues to lead to confusion in implementation, is costly for stakeholders, and ultimately hinders patient care. We believe this Administration can re-invigorate efforts to clarify and improve the application of the law for the benefit of all.

We applaud ONDCP for including parity in their policy priorities for the coming year. We urge you to begin the actions outlined immediately, particularly the development of "a working group with health care insurers and employers to promote the full implementation of MHPAEA to eliminate discriminatory barriers to mental health and substance use disorder services."[3] We look forward to bringing the payer's perspective to the conversation on strengthening the behavioral health system and ensuring patients realize the benefits of MHPAEA.

Strengthen and expand the behavioral health workforce. We encourage ONDCP to

[3] The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One, April 2021.

advocate for solutions to expand access to care, and address ongoing workforce shortages across the country in order to help ensure people who need MH and/or SUD treatment get the care they need. As one first step, we ask that the Administration and Congress work to increase funding to behavioral health providers so that we have an adequate workforce to meet the increasing need for MH and SUD services. We recommend expanding eligible Medicare providers to include marriage and family therapists (MFTs), mental health counselors (MHCs), and certified peer support specialists.

- *Medicare coverage of mental health counselors and marriage and family therapists.* Recognition of MHCs and MFTs as Medicare providers would increase the pool of eligible mental health professionals by over 200,000 licensed practitioners. Studies have shown that these providers have the highest success and lowest recidivism rates with their patients as well as being the most cost effective.[4] We encourage you to work with Congress to pass the Mental Health Access Improvement Act (S.828/H.R. 432), which recognizes MHCs and MFTs as covered Medicare providers, helps address the critical gaps in care, and ensures access to needed services.

- *Medicare coverage of peer support services.* Certified peer support specialists can be vital in providing support to people living with mental health conditions and SUDs. These paraprofessionals are individuals with lived experience of recovery from a MH disorder or SUDs. This evidence-based practice helps individuals navigate the often-confusing health care system, get the most out of treatment, identify community resources, and develop resiliency. Due to the COVID-19 pandemic, engagement with treatment and care has been disrupted, but finding and utilizing support in a timely manner can help mitigate negative health outcomes of the disruption. Recently, the Promoting Effective and Empowering Recovery Services in Medicare (PEERS) Act of 2021, H.R. 2767/S.2144, was introduced. This legislation is an important step in recognizing the unique role of peer support specialists in helping individuals better engage in services, manage physical and mental health conditions, build support systems, and, ultimately, live self-directed lives in their communities.

Ensure health coverage for individuals released from jails and prisons. ABHW strongly supports H.R. 955/S.285, the Medicaid Reentry Act of 2021, to grant Medicaid eligibility to incarcerated individuals 30 days prior to their release to promote the health care needs of individuals transitioning back into communities. According to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental illness. Of those with serious mental illness, approximately 75 percent also have a co-occurring SUD. Allowing incarcerated individuals to receive services covered by Medicaid 30 days prior to their release from jail or prison will expand access to vital mental health and addiction services. Equipping individuals with timely access to addiction, mental health, and other health-related services before release, will facilitate the transition to community-based care upon release that is necessary to help break the cycle of recidivism. This is even more critical in the midst of the COVID-19 pandemic.

Allow Insurers access to prescription drug monitoring programs (PDMPs). Successful

[4]D. Russell Crane and Scott H. Payne, "Individual Versus Family Psychotherapy in Managed Care: Comparing the Costs of Treatment by the Mental Health Professions," Journal of Marital & Family Therapy 37, no. 3 (2011): 273-289.

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).[5]

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 ONDCP consider ways to encourage states to allow plans to utilize PDMPs to assist with patient care.

Promote the integration of care. 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 office with a behavioral health care manager. Data has proven CoCM to be an effective model that integrates care, expands access, and improves outcomes.[6]

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 ONDCP to explore proposals that would help expand the use and adoption of CoCM.

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[5] 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.

[6] 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.

Invest in technological infrastructure. ABHW supports initiatives to propel broader electronic health record (EHR) adoption among mental health and substance use treatment providers. This includes urging 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, we advocate and recommend to Congress that they adopt statutory amendments to Section 6001 requiring CMMI to finance these much-needed incentives.

Reduce fraud and abuse in SUD treatments. ABHW members have witnessed firsthand the fraud in some SUD treatment facilities in areas of licensure, accreditation, administrative and billing practices, quality, and enrollment. ABHW urges ONDCP to consider the following to address fraud and abuse in SUD treatment:

- Develop a clear operational definition of recovery homes that accurately delineates the type of services offered.
- Ensure that all facilities are licensed and fully accredited to provide SUD services.
- Identify, disseminate, and adopt quality standards, best practices, and model policies to ensure the appropriate level of care and treatment for patients. Examine fraudulent administrative and billing practices of these facilities.
- Identify "patient brokering" practices that often result in kickback payments and deceptive marketing and advertising practices and outline procedures for law enforcement to address.

Increase focus on crisis services. ABHW supports an evidence-based continuum of crisis care for individuals experiencing a behavioral health crisis. We are in the process of internally discussing how we can be impactful on this issue and look forward to working with ONDCP to promote access to quality crisis services.

Thank you for the opportunity to provide suggestions to address important behavioral health policies. If you have any questions or would like to discuss ABHW's policy priorities please contact Deepti Loharikar, Director of Regulatory Affairs, at loharikar@abhw.org or 202-505-1834.

Sincerely,

Pamela Greenberg

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