ABHW
Advancing Health Care Policy
for Mental Health and Addiction

March 18, 2020

Honorable Donald W. Rucker, M.D.
National Coordinator for Health Information Technology
Department of Health and Human Services

Re: 2020-2025 Federal Health IT Strategic Plan

Dear Dr. Rucker,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Office of the National Coordinator for Health Information Technology's (ONC) 2020-2025 Federal Health IT Strategic Plan (Strategic Plan). Our thoughts 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.

Goal 1: Promote Health and Wellness. ABHW fully supports ONC's goal of promoting health and wellness by improving individual access to health information, advancing healthy and safe practices through health information technology (IT), and integrating health and human services information. We agree that a key aspect of person-centered care is empowering individuals through access to their health information as it allows patients to be more engaged in the care and management of their health. We look forward to working with ONC to achieve this goal.

Goal 2: Enhance the Delivery and Experience of Care. ABHW members are committed to ensuring that patients receive the care they need. As such, we recommend ONC consider the following as ways to improve the care delivery and patient experience:

1. *Aligning 42 CRF 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. A disruption can be caused in SUD treatment by 42 CFR Part 2 (Part

2), which 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, 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 treatment, payment, and health care operations) 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. As such, ABHW strongly supports aligning Part 2 requirements with HIPAA and urges ONC to coordinate with Congress and other regulatory agencies to address this important issue.

2. *Eliminating Barriers to Treatment Availability*

ABHW recommends ONC focus on eliminating barriers to MH and SUD treatment availability by expanding access to such treatments 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 that approximately 1 in 5 adults have a mental illness and 1 in 12 have a SUD coupled with the fact that there is a growing shortage of behavioral health providers to respond to this significant need for services, the expansion of telehealth is vital to help address the gap in timely access to necessary treatment.

Specifically, 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. Telebehavioral health creates an equitable treatment option to those with limited or no access to behavioral health services and can improve access, clinical efficacy, coordinated care, and cost-effectiveness. Legislation and regulation to date has largely targeted reimbursement for telehealth services and not on promoting its utilization and expansion. We submit the following for ONC's consideration:

- Lessen the barriers created by the Ryan Haight Act that prevent providers from prescribing certain medicines 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.

- Expand the list of eligible Medicare providers to include all behavioral health practitioners who are licensed to practice independently. Doing so will not only help increase access to telehealth by growing the pool of available providers, it will also help reduce costs because these providers provide quality, evidence-based care that is oftentimes a less expensive alternative to a doctor's care.

- Address state licensure issues to allow providers to deliver telehealth services across state lines.

3. *Increasing the Size of the Addiction Service Workforce, and Treatment and Recovery Infrastructure*

We recommend that ONC 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 the patients receive quality SUD treatment from an appropriately trained workforce.

Additionally, we recommend working with the Drug Enforcement Administration (DEA) to eliminate the practitioner waiver to prescribe buprenorphine. 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 opioid use disorder (OUD) and help individuals overcome addiction.

4. *Reducing Stigma and Making 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. 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 ONC to reduce stigma related to SUD.

Goal 3: Build a Secure, Data-Driven Ecosystem to Accelerate Research and Innovation. ABHW urges ONC to support policies that place a priority on enhancing evidence-based addiction treatment. ABHW has submitted comments to the Office of the National Drug Control Policy (ONDCP) on the following areas of focus and urge ONC to coordinate with ONDCP as appropriate.

- Develop and promote quality standards for services provided by MH and SUD treatment programs and providers, which may include licensure, third party oversight, and performance evaluations. Adoption of quality measures and standards could be used to promote accountability through certification and/or accreditation programs.[1]

- Identify and eliminate fraud in the SUD treatment space. In addition to quality measures, other areas of focus could include working to eradicate deceptive advertising by SUD treatment facilities, increasing penalties for body brokers (individuals who knowingly and willfully pay or receive kickbacks in return for referring a patient to a recovery home, clinical treatment facility or laboratory), and establishing new oversight structure for recovery/sober homes.

- Develop and implement processes for educating and supporting physicians on evidence-based protocols and treatment plans for SUD patients.

- Leverage data analytics to proactively identify patients who may be at risk for SUDs and who could benefit from early intervention.

[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) includes evidence-based practices and accreditation among their "five signs of quality treatment" and several organizations, including Shatterproof, the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Alliance for Recovery Residences (NARR), and the American Society of Addiction Medicine (ASAM) are involved in these important efforts. These efforts range from developing outcome measures and results-based care models to developing certification and accreditation programs for recovery housing and opioid treatment programs. A stronger quality measurement and accreditation/certification infrastructure for MH/SUD treatment would also make it easier to identify ineffective and/or fraudulent SUD providers.

<u>Goal 4: Connect Healthcare and Health Data through an Interoperable Health IT Infrastructure</u>.

1. *Expanded Access to PDMPs*

ABHW agrees that a strong interoperable Health IT infrastructure will benefit the coordination of care for patients and ultimately, improve their quality of care. 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 monitoring programs (PDMPs)[2] so that they can have a more complete picture of the use of controlled substances in a given community.

PDMPs are 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.

Despite this success, very few states permit Medicaid managed care organizations, insurance carriers, or private health plans access to PDMP data. If allowed access, these entities could identify patients at risk of overdose or complications because they are seeking prescriptions using multiple providers and paying for them through their insurance or with cash. 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 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; they can also become a strategic partner in preventing and identifying abuse. As such, we urge ONC to coordinate with the Centers for Medicare and Medicaid Services (CMS) and support any policies that would allow health plans to access PDMP data.

[2] 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.

2. *Improved Partnerships Between HIE Entities*

In addition to considering health plan access to PDMPs, we also urge ONC to consider the benefits of improved partnerships between Health Information Exchange (HIE) entities. ONC has previously noted that many patients with behavioral health concerns often have comorbid physical conditions, and would benefit from the "whole picture" view that a secure and timely exchange of information would deliver. As such, we strongly believe such partnerships, by providing an enhanced view into a comprehensive member record, may ultimately result in better care coordination Utilization of this data can also help to accelerate research and innovation as outlined in Goal #3.

3. *Address Issues with Encounter Data*

Another area of consideration for ONC is the collection of encounter data as it pertains to ONC's requirements for data sharing and capturing and moving towards value-based care. CMS requires states to collect service utilization data, known as encounter data, from Medicaid managed care organizations. While we appreciate that this data is necessary to ensure appropriate rates and that beneficiaries in Medicaid managed care are receiving covered services, we believe that the reporting requirements utilized by the states ultimately impede the implementation of value-based arrangements. This is especially concerning at a time when behavioral health is correctly moving towards greater value. We believe that focusing heavily on transactional processes, such as capturing encounter data, detracts from value-based care. As such, ABHW encourages ONC to coordinate with CMS on this important issue and also account for value when considering ONC's requirements for data sharing and capturing. We believe changes to these requirements would potentially ease operational burdens and incentivize value-based care arrangements.

Conclusion

Thank you for the opportunity to comment on ONC's Strategic Plan. Please feel free to contact ABHW's Director of Regulatory Affairs, Deepti Loharikar at loharikar@abhw.org or (202) 449-7659, with any questions.

Sincerely,

Pamela Greenberg

Pamela Greenberg, MPP
President and CEO