ABHW
Association for Behavioral Health and Wellness
Advancing benefits and services in mental health, substance use and behavior change.

Statement of
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Governor Christie and members of the Commission, thank you for inviting me here today.

My name is Pamela Greenberg, and for the last 19 years I have served as the President and CEO of the Association for Behavioral Health and Wellness (ABHW). ABHW is the national voice for payers that manage behavioral health and wellness services. ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health and wellness to 170 million people in both the public and private sector. Our members include both specialty behavioral health organizations (BHOs) that provide insurance coverage for mental health and substance use disorders and health insurance companies that provide insurance coverage for both physical and behavioral health. Our association supports policies that expand access to evidence based, quality care.

I'd like to start by reminding everyone in the room and those who are watching via the webcast that addiction to opioids or other substances is a chronic illness, not a bad habit or failure of will, and we must treat it as such. Opioid use disorder affects all segments of our society. If we can shift the public's perception and eradicate stigma associated with substance use disorders we can make progress in helping people feel comfortable sharing their personal stories and seeking the treatment they need. ABHW and its member companies run a campaign, Stamp out Stigma, and the goal of that campaign is to recognize when you or your loved ones need help; reeducate others to help them learn there is help and hope; and, reduce stigma.

Our member companies are committed to helping defeat the opioid epidemic. They support a continuum of evidence based, person-centered care to treat individuals with an opioid use disorder (OUD), including medication assisted treatment (MAT). Use of MAT as part of a treatment plan dramatically improves the chances of recovery and decreases the relapse rate. Our members work to identify and prevent addiction where they can; and where they can't, they help

individuals with an opioid use disorder get the appropriate, evidence based treatment to recover and lead full, productive lives in their community with their families and loved ones.

Today I will highlight three areas our member companies focus on to address the opioid crisis. They are data and early identification, the provider shortage, and neonatal abstinence syndrome (NAS). I will also highlight ABHW's recommendations to the Commission for your final report.

ABHW Member Company Actions

Data and Early Identification

The identification of individuals at risk of opioid dependence is a critical step in helping stop overdose and death. To do this, some ABHW members employ drug utilization review (DUR) programs. These programs flag members who are being treated for opioid dependence but are still filling opioid prescriptions (a good indicator that the person may relapse). DUR programs also help reduce the risk of overdose or complications by notifying a pharmacist when individuals are also filling opioid prescriptions at another pharmacy or have prescriptions for other drugs that may have a counter interaction with their opioids. Other companies analyze claims data across both pharmacy and medical benefits to detect opioid use patterns that suggest possible misuse by individuals and then they reach out to the person, or notify their health care provider, about the situation. Additionally, some members are using their data to better understand trends in opioid usage, track prescribing patterns, and explore the conditions for which opioids are most commonly prescribed.

Provider Shortage

We all are painfully aware that there are an inadequate number of qualified substance use treatment providers and licensed health care professionals trained to support individuals with substance use disorders. A major cause of MAT underutilization is the lack of providers with specialty training who are approved and willing to treat individuals with an opioid use disorder. ABHW members have taken several steps to address this shortage and build provider networks in a manner that helps ensure that they have capacity to meet the needs of their consumers. Many of our members are able to expand the availability of care and treatment through telehealth services. Some companies have also found peer services to be useful in helping people with an addiction upon entrance into an emergency room and then later with their recovery. Community supports are also valuable to help people engage and remain in treatment.

At least one member company partners with Project ECHO (Extension for Community Healthcare Outcomes), a telementoring platform that links specialists with nonspecialists through virtual clinics, where the specialists mentor participants and share their knowledge through case-based learning and guided practice. This "hub-and-spoke" learning model enables primary care providers and other clinicians to develop the skills need to treat patients with complex, chronic conditions, such as opioid addiction, within their own communities. In this instance, our member's clinical team serves as the ECHO hub to train community-based practitioners on

MAT. This program helps educate providers about the latest advancements in evidence based care, integrates providers into the opioid use care continuum, increases access to evidence based treatments, and improves access to opioid use disorder treatment. This model is particularly useful in historically underserved areas and areas with a psychiatric shortage.

Neonatal Abstinence Syndrome

Every 25 minutes a baby is born suffering from an opioid withdrawal. This is known as neonatal abstinence syndrome (NAS) and from 2000 to 2012 we saw a five-fold increase in babies born with NAS. ABHW member companies work diligently to address this dreadful problem and follow established standards of care for newborns with NAS. One example is a company that identifies pregnant women with a substance use disorder and engages them in case management. If the woman agrees, she is referred to a practitioner that is familiar with treating pregnant women with a substance use disorder. The case manager supports and follows the woman through delivery and beyond. For at least one year, the infants are also followed if the mother allows the health plan to remain engaged. Furthermore, depending on the newborn's geographic location he or she can be discharged to a specialized NAS treatment facility that can wean the infant from opioids, provide physical therapy and medical care, and give support and counseling to the parents.

ABHW Recommendations for the Commission Report

ABHW has the following recommendations for the Commission to consider.

1. Align 42 CFR Part 2 (Part 2) with the Health Insurance Portability and Accountability Act (HIPAA)

42 CFR Part 2 is an outdated 1970s regulation that limits the use and disclosure of patients' substance use records from certain substance use treatment programs. This can prohibit payers from sharing this information with the health care providers on the front line caring for patients suffering from opioid and other substance use disorders. The outdated regulation severely constrains the health care community's efforts to coordinate care for persons with substance use disorders and ABHW members say Part 2 is one of the biggest – if not the biggest – barrier to fighting the opioid crisis.

ABHW leads a Partnership of forward-thinking health care organizations committed to aligning Part 2 with HIPAA in order to improve care delivery and patient outcomes. Without the ability to share substance use disorder records, insurers, doctors, hospitals, pharmacists, electronic health record vendors, pharmaceutical companies, and others are limited in what they can do to assist in the nation's efforts to eliminate heroin and prescription drug abuse.

Aligning Part 2 with the treatment, payment, and health care operations (TPO) language in HIPAA through a legislative fix or regulatory guidance via the existing Supplemental Notice of Proposed Rulemaking to the Part 2 final rule is necessary. We urge the Commission to work with

Congress to further ensure that providers and organizations have all the information necessary for safe, effective, high quality treatment and care coordination that addresses all of a patient's health needs.

2. Reform Prescription Drug Monitoring Programs (PDMPs)

ABHW would like to see expanded access to PDMP data to better identify individuals at risk of prescription drug abuse and enable greater coordination across health care entities.

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.

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 recent *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, many states still do not require providers to check their PDMPs before prescribing.

Very few states permit Medicaid managed care organizations (MCOs) and private health plans or pharmacy benefit managers (PBMs) 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 and PBMs 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 clinical decision making and patient health care and safety; they can also become a strategic partner in preventing and identifying abuse.

Furthermore, PDMPs do not contain methadone data because methadone is viewed as a medical benefit and not a prescription drug benefit. Factoring in methadone data would certainly assist health plans, states, law enforcement, and others to better identify abuse and misuse.

The Commission should instruct each state to have a PDMP which private health plans, Medicaid, Medicare, and PBMs can access; to which prescribers are providing information; and which allows information to be exchanged across state lines. The creation of a national PDMP would also address these concerns.

3. Ease the Burden on Primary Care Physicians (PCPs) Willing to Prescribe MAT

Through regulation issued on July 8, 2016, the Secretary of Health and Human Services raised the cap on the number of patients being treated with buprenorphine by a practitioner to 275. Because this helps to decrease the barrier that some patients face in finding a provider to treat their opioid addiction, ABHW was supportive of this increase; and we recommend lifting the cap entirely. Additionally, we recommend easing the burden on PCPs willing to prescribe MAT, even though the patient cap has lifted, it is not often reached, as providers are unable or unwilling to take on patients for various reasons. Development of educational resources and additional training, including online, will help make PCPs more comfortable with MAT and with interacting with persons with a substance use disorder. One example is collaborative education programs that include both PCPs and behavioral health experts. Another idea is to provide incentives to encourage PCPs to take care of their own opioid dependent members. Bundled payments might also help with MAT provided by a PCP.

Another major barrier for PCP prescribing is lack of access to consultation with addiction specialists for complications that occur during treatment. To date, integrative care has focused more on mental health conditions; we should have equal linkages for substance use services, either in person or via telecommunication. Codes for use and reimbursement of substance use consultation via telephone by addiction medical specialists and financial incentives to create pairing of addiction providers with primary care medical homes could help drive MAT adoption. A common problem is that PCPs are not able to address complications such as relapse or family issues, and financially funded linkages with substance use providers could help eliminate this barrier.

4. Require Evidence Based Care in Accordance with National Standards

The standard of care for opioid use disorder is to treat the disease with a combination of medication and evidence based psychosocial interventions. As such, ABHW suggests creating a mechanism to ensure providers are aware of, and practicing, evidence based care in accordance with national standards, such as the American Society of Addiction Medicine's (ASAM) National Practice Guideline. This guideline was created to provide information on evidence based treatment of opioid use disorder. It addresses all the FDA-approved medications available to treat addiction involving opioid use and opioid overdose in a single document, aiming to help clinicians make evidence based clinical decisions when prescribing pharmacotherapies to patients with opioid use disorder. Training providers, as needed, in ASAM criteria would help ensure they are providing evidence based care. Additionally, it would be beneficial if there was an online database of opioid quality improvement initiatives by and for medical and behavioral health practices that can help them determine next steps for improving patient care for chronic pain and substance use disorders.

5. Provide Better Access to Telehealth Services

Telehealth has been proven to drive important advancements for our patients, expand access to care, improve health outcomes, reduce the inappropriate use of psychotropic medications,

overcome the stigma barrier, and cut costs. Given the rise in the opioid epidemic and the growing shortage of behavioral health providers, the expansion of telehealth is an important option for the Commission to consider.

Many barriers to telehealth exist, and the elimination of such obstacles would improve access and quality of care for people with addiction. One significant barrier is the Ryan Haight Act, a law designed to combat the rogue internet pharmacies selling controlled substances online that proliferated in the late 1990s. This law does not allow controlled substances to be delivered, distributed, or dispensed by means of the internet without a valid prescription; and a valid prescription is one that is issued by a practitioner who has conducted at least one face to face medical evaluation of the patient. ABHW recommends making necessary changes to this law to eliminate, in all states where it exists, the requirement of a face-to-face evaluation prior to a telehealth visit.

Additionally, under section 1834(m) of the Social Security Act, Medicare pays for telehealth services when the service is furnished by an eligible practitioner; a patient is located in an originating site; and the originating site is in a rural area. Removing the originating site and geographic restrictions to Medicare reimbursement and increasing the list of eligible providers would provide better access to telehealth services for the more than 6 of every 1,000 Medicare beneficiaries diagnosed with an opioid use disorder.

6. Endorse the Centers for Disease Control and Prevention (CDC) Guideline

The Centers for Disease Control and Prevention (CDC) noted that prescriptions for opioids written by health care providers dropped 13.1 percent between 2012 and 2015. This is due, in part, to the fact that doctors are prescribing opioids less often, and the average dose they are prescribing has dropped. However, the CDC has also reported that the length of prescriptions has increased from an average of 13 days in 2006 to 18 days in 2015; and U.S. doctors are still prescribing three times as many opioids as they were in 1999 and three times more than European doctors.

As part of the effort to continue to reduce the amount of opioid prescriptions, we recommend the Commission endorse the recent CDC Guideline for Prescribing Opioids for Chronic Pain. This document provides recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Ensuring that providers are following these guidelines will translate into more appropriate prescribing of chronic pain medication and help to solve the opioid crisis.

7. Eliminate the Institutes for Mental Diseases (IMD) Exclusion

The IMD exclusion in Medicaid limits beneficiary access to needed and appropriate care. In some areas IMDs are the only hospitals available. In other locations, because of the exclusion, many Medicaid enrollees with acute behavioral health needs are sent to general hospital emergency departments, although these facilities often lack the resources or expertise to care for such patients. ABHW supports elimination of the IMD exclusion, as an interim step, we also

support waiver approval for states to eliminate barriers to treatment resulting from the federal Institutes for Mental Diseases (IMD) exclusion within the Medicaid program.

8. Investigate Fraudulent Treatment Providers

In the last few years we have experienced a dramatic increase in the number of fraudulent substance use treatment providers, mostly with sober homes and residential facilities. These facilities are often unlicensed and are taking advantage of individuals with an addiction. The fraud consists of gaming the health care system, brokering of patients, and providing care (if care is provided at all) that is not evidence based. The services offered by these providers cost more, have higher readmission rates, and people are dying under their care. We have little control over these entities because they are out-of-network providers and consumers are lured into going to these facilities. More attention needs to be paid to this issue and increased federal and state oversight is needed in this area.

We are aware of the Commission's interest in mental health parity. ABHW supported the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and played a leadership role in the passage and implementation of this historic law. Since its passage, ABHW members companies have done the required parity analyses and implemented its requirements, when clarifications are needed we have sought them out from the regulators. We support consistent application and enforcement of the law and are currently working with a wide variety of stakeholders on a parity accreditation tool.

Thank you for the opportunity to speak to you today. We hope that you will include our recommendations in your final report. ABHW supports the goals of the Commission and is committed to working with all interested parties to help eradicate the opioid epidemic in our country.