February 12, 2018

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the National Council for Behavioral Health, thank you for the opportunity to share recommendations on actions the U.S. Congress can take to improve prevention and access to treatment for opioid use disorder among beneficiaries enrolled in Medicare and Medicaid. We appreciate your attention to this critical issue and look forward to working closely with you and your colleagues on the Senate Finance Committee as you undertake these key efforts to combat the opioid epidemic.

The National Council for Behavioral Health is the unifying voice of America's health care organizations that deliver mental health and addictions treatment and services. Together with our 2,900 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

We are grateful for the opportunity to provide comments on the following questions outlined in your February 2, 2018 letter:

1. How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?

Payment incentives for comprehensive chronic pain Intervention and integrated SUD care. Despite the availability of numerous evidence-based interventions for pain management, chronic pain specialty clinics typically focus disproportionately on procedural interventions such as joint injections and prescription of medication. These clinics frequently do not offer interventions such as physical therapy and biofeedback known to improve responses to pain without pharmacologic intervention. Moreover, though mental illness and substance use disorders are associated with a higher likelihood of experiencing chronic pain, all too often these clinics do not include treatment for co-occurring substance use disorders, co-occurring mental illness, or mental illness secondary to the chronic pain such as depression. The National Council recommends that Medicaid and Medicare should offer a bundled payment for comprehensive chronic pain interventions that include all of the above components or offer pay-for-performance (PFP) penalties and/or bonuses for increasing the portion of cases that receive chronic pain treatments other than prescription medication and joint injections.

2. What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?

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Improved coverage of HBAI codes and non-pharmaceutical interventions in Medicare and Medicaid. The National Council recommends that both Medicaid and Medicare should cover the Health Behavior Assessment and Intervention (HBAI) codes, which pay for addressing the psychiatric and psychological impacts of chronic disease, including chronic pain. Use of the HBAI codes allows addiction and mental health professionals to be paid for working with psychiatric symptoms such as depression and anxiety, and to treat chronic pain patients without assigning them a separate mental health diagnosis. Many states do not currently cover these codes and do not cover or have significant limitations on coverage for non-pharmaceutical approaches chronic pain management such as physical therapy and chiropractic services. Medicaid programs should be encouraged, incentivized, or mandated to cover the comprehensive array of services which are of significant benefit in chronic pain.

3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment and treatment for OUD and other SUDs to improve patient outcomes?

Expansion of addiction professionals serving Medicare beneficiaries. The National Council urges the Committee to advance legislation to increase the addiction workforce in Medicare to address the opioid crisis. S. 1879—the Seniors Mental Health Access Improvement Act—would permit mental health counselors (MHCs) and marriage and family therapists (MFTs) to serve as providers of addiction and mental health services in the Medicare program. These professionals are trained and licensed to provide substance abuse and mental health services. They must obtain a master's or doctoral degree in a mental health discipline, have completed two years of post-graduate clinical supervision, and have passed a national examination in order to obtain a license to practice. There are over 200,000 licensed MHCs and MFTs in the United States, comprising over 40% of the independent practice behavioral health workforce and reaching Americans in counties without access to physicians/psychiatrists, psychologists, or other mental health and addiction treatment providers.

The Surgeon General's 2016 report on addictions specifically identified Medicare's restriction on health professionals as a barrier to delivery of substance abuse treatment services:

> "However, Medicare, and in some states Medicaid, restricts "billable" health care professionals to physicians (including psychiatrists), nurse practitioners and clinical nurse specialists, physician's assistants, clinical psychologists, clinical social workers, and certain other specified practitioners, and does not include as billable the multiple other licensed and certified professionals who are trained to provide services for substance use disorders."

The exclusion of MHCs and MFTs from Medicare impacts the Medicaid program. In most states, MHCs and MFTs are authorized Medicaid providers. However, MHCs are not available to individuals dually enrolled in Medicare and Medicaid. These dual-eligible individuals are required by federal law to have Medicare as their primary insurance provider, leaving Medicaid as secondary. Therefore, in order for Medicaid to pay for MHC or MFT services, providers must secure a denial of coverage letter from the Medicare program. However, Medicare will not provide the letter because these professions are not

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Medicare-eligible. Consequently, Medicaid beneficiaries seeking addiction treatment are limited in their provider pool because of Medicare's restriction.

It is also clear that many Medicare and Medicaid beneficiaries do not have access to addiction providers, particularly those living in rural and underserved areas. Fully 50% of rural counties in the United States have no practicing psychiatrists, psychologists, or clinical social workers. More than 110,000,000 million people live in mental health professional shortage areas. However, the Rural Health Research Center showed that only 18% of rural counties don't have mental health counselors or marriage and family therapists and there are twice as many of these professionals in rural counties as social workers, six times the number of psychologists, and thirteen times the psychiatrists. Congress can immediately expand access to addiction prevention and treatment by permitting MHCs and MFTs to directly bill Medicare for their services.

Increase types of services and providers reimbursed by Medicaid. A number of key interventions for people living with opioid use disorder or other substance use disorders are not covered by Medicaid under the federal payment prohibition on Institutes of Mental Disease. This payment prohibition should be modified to permit coverage and payment for short-term residential substance use treatment. Additionally, states should be incentivized and supported in expanding Medicaid coverage to include intensive outpatient programs (IOP) and the full continuum of recovery supports shown to help people living with addiction maintain a healthy and functional life in their communities.

Extend the Certified Community Behavioral Health Clinic demonstration in Medicaid. In recent decades, addiction treatment organizations have seen steadily decreasing resources while struggling to meet a growing demand for services, including dire increases in the need for treatment caused by the opioid crisis. Current payments under both Medicare and Medicaid for OUD and SUD services are frequently set well below the actual cost of providing care; as a result, provider organizations are stretched too thin to meet the full need for care in their communities. The Excellence in Mental Health and Addiction Act, an initiative that began in 2017, begins to address these challenges through a two-year, eight-state demonstration to expand Americans' access to addiction and mental health treatment in community-based settings.

The Excellence in Mental Health Act demonstration established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs), which provide a comprehensive range of addiction and mental health services to vulnerable individuals. In return, CCBHCs receive a Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs must provide nine types of services,1 with an emphasis on the provision of both substance use and mental health care, 24-hour crisis care, evidence-based practices, and care coordination.

Early results show that CCBHCs are fulfilling their promise of expanding access to timely, evidence-based care—and the results are particularly striking when it comes to opioid treatment. In November 2017, 100% of surveyed CCBHCs reported they have engaged in one or more activities to increase their opioid

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treatment capacity. CCBHCs receive a bundled, actuarially sound Medicaid rate based on their costs of providing care, including costs associated with hiring new staff such as licensed addiction counselors or peer addiction support specialists, implementing 24/7 crisis response programs, initiating or expanding medication-assisted treatment offerings, and training staff in required competencies such as care coordination and evidence-based practices.

Unfortunately, under current law, the demonstration is limited to eight states over just two years, though 19 states went through a year-long process to certify CCBHCs and plan their participation in the program. Senators Roy Blunt (R-MO) and Debbie Stabenow (D-MI) and Representatives Leonard Lance (R-NJ) and Doris Matsui (D-CA) introduced the Excellence in Mental Health and Addiction Treatment Expansion Act (S. 1905/H.R. 3931), which will extend the current CCBHC demonstration by one year and allow 11 additional states to join. By renewing and expanding the demonstration, Congress could expand behavioral health capacity and alleviate the pressure on our nation's jails and emergency rooms.

Require Medicare Advantage (MA) plans to contract with CCBHCs and other community behavioral health organizations. Though CCBHCs are required to serve all individuals regardless of coverage source or ability to pay with the same comprehensive set of services, they currently only receive their actuarially sound, cost-related payment rate (known as PPS) for Medicaid patients. This leaves CCBHCs struggling to make up the difference for uninsured individuals and patients enrolled in other sources of coverage such as Medicare. Congress can improve access to CCBHCs' comprehensive service array by requiring MA plans to contract with CCBHCs and pay the PPS rate for CCBHC services. Additionally, Congress can require MA plans to contract with other CBHOs that have not yet received CCBHC status but which provide comprehensive addiction and mental health prevention, treatment and recovery services.

4. Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting sufficient access to appropriate prescriptions?

Streamline electronic communication and availability of claims information to improve care management. State Medicaid programs struggle to adequately coordinate benefits for dual-eligible individuals to receive their pharmacy benefit through Medicare Part D. Effective coordination of benefits, including early identification of persons at risk for OUD and SUD, are greatly facilitated by real-time access to claims information. For dual-eligible individuals receiving their pharmacy benefit through Medicare Part D, any prescription that results in a clawback charge to the state for portion of the cost should generate a real time claim for the clawback charge that is handled through the same adjudication system (TrOOP Facilitator and Switch) that handles the payment transactions between Medicare, the wholesaler, and the manufacturer. Real-time claims information would give state Medicaid agencies the opportunity to do real-time care management addressing OUD and SUD risks and need for treatment.

5. How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

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Utilization of data analytics to identify high-volume prescribers. Medicare and Medicaid should utilize data analytics for both pharmacy claims and medical claims to identify high-risk patients and prescribers with high volumes of high-risk patients and provide patient specific feedback to the high-volume prescribers. Medicaid and Medicare pharmacy benefit payers should develop and utilize opioid quality indicators to identify provider performance gaps to identify providers that are performing below safe opiate use benchmarks. We recommend that these analytics should:

- Identify providers whose prescribing data falls outside of clinical standards and best practices;
- Identify patients' different levels of risk for the misuse and abuse of opioids;
- Apply predictive modeling based on claims data determining which practices have the biggest risk for misuse;
- Identify low/high-performing providers based on key metrics;
- Provide patient-specific feedback to low-performing providers on specific alternatives to improve their opiate prescribing skills and care coordination; and
- Track low-performing providers over time to assure improvement and refer low-performing providers who continue to not improve for audit by state and federal enforcement agencies.

The state of Missouri has implemented such activities and analytics in its Medicaid program, resulting in significant reductions in overall opiate use and risky prescribing patterns

6. What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives such as Prescription Drug Monitoring Programs?

Please see our comments pertaining to Question #4 above.

7. What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

Expansion of CCBHC initiative, per comments outlined under Question #3 above. The CCBHC demonstration was designed to support clinics in expanding service delivery and implementing the latest evidence-based practices and technologies to improve the quality and scope of care. Many of these activities have not been reimbursable under previous funding streams, making it impossible for organizations to implement the latest treatment innovations known to improve outcomes. CCBHCs nationwide report that the new payment rate has enabled them to open new service lines and leverage new technologies to improve care. Among many others, these activities include:

- Expanded capacity to provide 24/7 crisis care;
- Adoption of new technologies that support care delivery, such as mobile apps, web platforms and telehealth;
- Implementation of new care delivery partnerships with hospitals, schools, and law enforcement agencies;
- Expanded services to veterans and members of the armed forces;

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- Implementation of same-day access protocols so that every patient can be seen on the same day they are referred for services; and
- Improved outreach and engagement activities that reach patients outside the four walls of the clinic.

In a recent survey of 47 CCBHCs conducted by the National Council, 87% of those surveyed reported that they have seen an increase in the number of patients served. For the vast majority of CCBHCs, this represents up to a 25 percent increase in their patient caseload. The majority of CCBHCs report that most of their new clients had either not been enrolled previously in treatment despite having a mental health or substance use need, or were referred to treatment for the first time, an indicator of these organizations' ability to expand access to timely, evidence-based addiction and mental health care in their communities.

8. What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD and SUD on children and families?

Expansion of CCBHC initiative, per comments outlined under Questions #3 and #7 above.
CCBHCs' prospective payment rate supports numerous activities designed to improve health outcomes among children and families affected by OUD/SUD. These include partnerships with schools and school-based health clinics; the ability to offer care in the community or at home; the ability to hire child psychiatrists and other staff with a child- or family-focus; and care coordination activities among all the social service and health care agencies serving these children and families.

The National Council is grateful to the Senate Finance Committee for your consideration of these recommendations. For more information or with questions, please contact Chuck Ingoglia, Senior Vice President of Policy and Practice Improvement, at ChuckI@TheNationalCouncil.org or 202-684-3735.

Thank you again for your time and attention to this important issue.

Sincerely,

Linda Rosenberg

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