National Association for Behavioral Healthcare

Access. Care. Recovery.

8 July 2021

Ms. Regina LaBelle
Acting Director
Office of National Drug Control Policy
Executive Office of the President
1800 G Street, NW
Washington, DC 20503
2022Strategy@ondcp.eop.gov

Re: ONDCP request for consultation on the *National Drug Control Strategy*

Sent electronically

Dear Ms. LaBelle:

Thank you for inviting the National Association for Behavioral Healthcare (NABH) to provide consultation and comments for the biennial *National Drug Control Strategy* (Strategy). ONDCP's role in coordinating federal drug policy priorities and actions is vital to addressing successfully our nation's addiction crisis. I write to recommend the following administrative actions and policies to improve access to substance use disorder (SUD) treatment services.

ONDCP is aware of the data documenting the rise of opioid and stimulant drug use and addiction, as well as alcohol addiction. We recommend that existing funding be modified to better target and streamline substance use disorder (SUD) services, and that new funding and funding mechanisms are needed to support the existing infrastructure.

I. Telehealth and Other COVID-19 Flexibilities

The Covid-19 pandemic demonstrated telemedicine's relevance and capabilities as a treatment intervention in modern addiction treatment. We recommend:

A) Continuing audio-visual telemedicine flexibilities provided during the pandemic using common consumer electronics (computers, smart phones), as well as audio-only telemedicine; the latter is an imperative for many patients without smart phones or cellular connectivity.
B) Permitting hybrid telemedicine for medical evaluations and methadone induction in opioid treatment programs (OTPs) where the prescriber is using telehealth while the patient and other qualified health professionals are at the OTP. If this is not permitted, we request that the Substance Abuse and Mental Health Services Administration (SAMHSA) fund pilot studies to determine patient safety and efficacy of this model and/or provide a written clinical rationale as to why this telemedicine intervention is not permitted.
C) Make permanent buprenorphine prescribing for existing and new patients; issue Drug Enforcement Administration (DEA) final regulations (per the *SUPPORT Act)* that would authorize a telehealth exam in lieu of an in-person exam for issuing an electronic prescription of controlled substances for medication-assistant treatment (MAT).
D) Maintain reimbursement at in-person rates for telehealth services, including medication treatment, office-based services, and services and facility fees for intensive outpatient programs (IOPs) and partial hospitalization programs (PHPs) provided via telehealth. Staffing, facility, quality oversight and other costs remain constant despite the use of telehealth, and telemedicine may incur additional

costs. Maintaining in-person rates is necessary to continue the telemedicine revolution, maintain hybrid treatment models that improve access, and avoid leaving patients with SUDs behind.

E) Funding sources should provide meaningful incentives to states to adopt federal regulations and guidance standards to encourage uniformity of treatment standards, patient-to-provider ratios, and best practices. Under Covid, many states did not adopt the flexibilities provided by the federal government and patients were put at risk. Science and best practices, not state and local legislative or other processes should drive clinical and regulatory requirements. Abiding by science will help diminish geographic disparities in treatment and health outcomes, prevent patients from having to cross state lines to obtain more flexible treatment, and streamline policies for multi-state practices.

II. Medicare/Medicaid

A) The Centers for Medicare & Medicaid Services (CMS) should review Medicare, Medicare Advantage, and Qualified Health Plan reimbursement levels and strategies for substance use treatment services (for telehealth and non-telehealth services alike) to bring reimbursement for addiction providers to levels that are more consistent with their education, credentialing, and medical peers. SUD providers generally operate with lower margins than other specialty care providers, partly because reimbursement rates for services are often much lower compared to their medical peers.

B) CMS should encourage states to increase their reimbursement rates through Medicaid and Managed Care Organization contracts.

C) The OTP Medicare bundle was a great advancement in financing for SUD services. To incentivize rural care, assure sustainability over time, and align with coverage of similar healthcare entities, we recommend that CMS:
   - Establish a 17% rural OTP add-on payment
   - Establish a Medicaid payment rate floor (80% of the local Medicare rate), maintenance-of-effort requirement to prevent rate decreases and provide 100% FMAP for OTPs and OBOTs.
   - Update the Medicare OTP rate by the hospital market basket index.
   - Include the 6% ASP add-on for Medicare's drug portion of the OTP bundle when ASP data are available.
   - Create an add-on code or additional bundle for contingency management (CM) for patients in OTPs. This is essential for treating individuals with a co-diagnosis stimulant use disorders (StUDs), but there is also strong evidence for use with patients with opioid use disorders (OUDs).

D) Require Medicare to cover all intermediate levels of care for addiction treatment (e.g., freestanding intensive outpatient, partial hospitalization, residential) for substance use disorders and reimburse facility fees; collaborate with stakeholders to establish new conditions of participation.

E) Collaborate with Congress to remove the 190-day lifetime limit for inpatient psychiatric care.

F) Permit reimbursement based on state authorized credentialing, e.g., provide independent coverage for licensed counselors and certified addiction and peer counselors without services being 'incident to' those provided under the supervision of a physician.

G) Permanently eliminate prior authorization for medications to treat OUD in Medicare, Medicare Advantage and Qualified Health Plans. Encourage states to do the same in Medicaid and Medicaid Managed Care.

H) Collaborate with Congress to extend the mandatory coverage of MAT medications in Medicaid beyond 2025 (Section 1006(b)) of the SUPPORT Act.

I) Provide guidance to Medicaid agencies on contracting with managed care entities to assure that medical necessity determinations and utilization management practices are based on generally accepted standards of care for example, the American Society of Addiction Medicine (ASAM). Incorporate ASAM principles into the Medicare Advantage and Qualified Health Plan policies that operate in the insurance marketplace.

J) Report the findings from the *SUPPORT Act* SUD treatment demonstration project and develop guidance to states on improving addiction treatment providers' reimbursement and participation in Medicaid. Extend program to an additional 15 states.
K) Implement increased rigor and support to assure that SAMHSA block grant recipients that are providers enroll to receive reimbursement from Medicaid and that the Substance Abuse Prevention and Treatment (SAPT) block grant is used as the payer of last resort.
L) Align managed care reporting requirements within and across states to reduce reporting burden on providers.

III. Contingency Management

To encourage the rapid and broader adoption of CM for stimulant use and other disorders, we recommend:

A) Use all federal agency communication channels (state Medicaid Director letters, Medicare Learning Network, etc.) to establish that CM is a highly effective evidence-based practice.
B) Clarify the Office of Inspector General (OIG) opinion to assure providers and states that they will not be subject to increased or punitive actions from the OIG if incentives exceed the annual ceiling of $75 per patient per year, which is not commensurate with the evidence-based practice (incentives are effective at $100-200 per month, including monetary rewards).
C) Publish appropriate guardrails for the use of CM to protect against fraud and abuse.
D) Establish Medicare and Medicaid billing codes for the clinical procedural elements of CM.
E) Assure that all technical assistance channels (SAMHSA ATTCs, Health Resources and Services Administration (HRSA) Area Health Education Centers (AHECs), CMS, others) are promoting the actual evidence-base of CM. There is confusion in the marketplace that needs clear communication and clarification.
F) Do not require CM digital solutions to be Food and Drug Administration (FDA)-approved while this field of innovation continues to develop.
G) Fund CM pilots through SAMHSA, HRSA, CMS innovation center, 1115 waivers, Accountable Care Organizations (ACOs) Beneficiary Incentive Programs, and value-based (e.g., opioid treatment program bundle) or risk-based contracting systems and other avenues to stimulate education and adoption of the intervention.
H) Bring all federal stakeholders together to assure commonality of purpose and coordination of execution of promoting the use of CM.

IV. Workforce Expansion

Federal data collection assists states, educators, providers, and others with understanding the strength of the workforce and developing and expanding the workforce, as well as providing an understanding of service availability, among other things. However, some federal data sets do not comprehensively delineate substance use data.

A) HRSA collects information about geographic areas, population groups, and facilities that are designated as professional shortage areas (HPSAs). However, HPSA collection conflates mental health and substance use, making it difficult to discern the separate needs for professionals and non-professionals as well as the geographic areas in which they are needed. While there is broad interest in integrating these services clinically, the training, credentialing, and job classifications for mental health and substance use are often different. We recommend that HRSA collaborate with SAMHSA to use the buprenorphine locator and other SAMHSA data collection efforts, and to supplement that data, to more fully support workforce data collection and reporting for SUD,

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B) A similar issue exists within the U.S. Labor Department (DOL) data collection. We recommend that all workforce data collection and reporting efforts within DOL also separate substance use from mental health providers and services.
C) DEA should standardize into guidelines the oversight and auditing of buprenorphine practices across the country, such that auditors and practitioners in all states have common expectations and experiences of the audits similar to other medical providers that are subject to oversight audits by independent parties. The DEA should collaborate with stakeholders to develop consistent and professional oversight practice and local DEA authorities should have less discretion in deviating from established guidelines. NABH supports program oversight and understands that the government requires assurance against fraud and abuse. However, DEA audits are inconsistent from state to state, engender fear, and dissuade practitioners from prescribing MAT.
D) Collaborate with states to assure that the raising of credentialing standards are not unduly restricting the workforce. There have been reports that individuals in recovery who have been working as peers for years have not been grandfathered under new credentialing standards. There have been additional reports of nurse practitioners and others not being grandfathered, as well as a rise in standards that are not always necessary while making recruitment more difficult.

V. Medication Assisted Treatment

A) The U.S. Department of Justice (DOJ) should assure that individuals with a substance use disorder have access to all forms of MAT while in jail and prison. We also recommend that DOJ collect and publish data on the provision of *all three forms* of FDA-approved medication; currently data is collected for only buprenorphine and naltrexone.
B) Direct additional funding to stimulate hub-and-spoke models for OUD medication treatment that is initiated in hospital settings and continued in the community. Emergency Departments are often reluctant to initiate medication if community providers cannot continue the treatment. It is critical that people not be discharged without exposure to addiction treatment medication, as this leads to high levels of overdose post-discharge. In addition, we recommend fostering increased use of medications for alcohol use disorder, also underused by hospitals and the general medical community.
C) SAMHSA should work with states to streamline approvals for new start-ups of programs in good standing within the state. States and localities impose burdensome requirements and long delays, often related to low staffing at state agencies

NABH represents addiction and mental healthcare systems that provide treatment in inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as medication assisted treatment (MAT) centers and other facility-based outpatient programs for children, adolescents, adults, and older adults in almost every state. We represent approximately one-quarter of the nation's OTPs.

Thank you for your consideration. If you have any questions, please contact Sarah Wattenberg at sarah@nabh.org or me at shawn@nabh.org.

Sincerely,

Shawn Coughlin
President and CEO