Testimony for the

Senate Committee on Finance

United States Senate

Examining the Opioid Epidemic: Challenges and Opportunities

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Chairman Hatch, Ranking Member Wyden and members of the Senate Committee on Finance, thank you for holding this hearing on the pressing public health problem of prescription drug abuse. My name is Allan Coukell. I am a pharmacist and I direct health programs for The Pew Charitable Trusts. Pew is an independent nonpartisan research and policy organization that works to develop and support policies that will help reduce the inappropriate use of prescription drugs while ensuring that patients with medical needs have access to effective pain management.

Nearly all of us have been touched by the epidemic of prescription drug abuse or have heard the horrific personal stories of its effects on peoples' lives. It is a problem cities and rural states, of rich and poor, of old and young. This is a public health crisis across the nation, and the statistics are staggering. Almost 19,000 Americans died in 2014 from prescription opioid overdoses. This is the equivalent of 52 people a day, and represents a 16 percent increase in deaths from the year before.[i] What is particularly tragic is that these deaths are preventable.

The epidemic is a public health crisis that requires a multi-faceted response. We need strategies to prevent drug abuse and addiction. We need to identify patients who are at risk. We need to prevent people from overdosing. We need to educate providers about how to prescribe opioids responsibly. And we need to ensure that people who do become addicted get the help they need. We must also not lose sight of the importance of providing adequate pain management to people who need it.

Today, I would like to focus on one policy that will improve patient care and reduce the chance of overdose by ensuring that patients who are at risk of harm from multiple opioid prescriptions get their pain medications from one doctor or one pharmacy. These programs, known as patient review and restriction (PRR) programs, are in wide use in Medicaid and commercial plans. But they are prohibited in Medicare. Senators Toomey, Brown, Portman and Kaine have shown great leadership by introducing the Stopping Medication Abuse and Protecting Seniors Act of 2015, which would allow Medicare to use this important tool to protect seniors. Pew applauds their work on this important legislation.

Patient Review and Restriction Programs

PRRs are a tool to identify individuals at risk of overdose and other harms, and to ensure they receive coordinated care. PRRs specifically identify patients who are receiving these drugs from multiple healthcare providers, assigning them to designated pharmacies and prescribers to obtain their controlled substance prescriptions. Through this mechanism, PRRs allow plan sponsors and providers to improve care coordination and prevent inappropriate access to medications that are susceptible to abuse.

Let me explain in detail how these programs work. First, potentially at-risk patients are identified based on specific, predetermined criteria, which may include the number of different prescribers and pharmacies visited to obtain controlled substance prescriptions. Other risk criteria may include duplicative therapies, emergency room visits and total daily dosage of the drugs. Once patients have been identified, a clinical review is performed, usually by a medical professional, to determine if the beneficiary's prescription drug use is inappropriate. Patients, such as those in hospice or receiving treatment for certain cancers, are typically excluded from these programs. The beneficiary is then notified of his identification as at risk and his subsequent enrollment in a PRR. The beneficiary is provided the right to appeal the decision and the choice to submit provider preferences.

Forty-nine Medicaid programs currently operate PRRs, and Pew has researched outcomes from these programs. Tennessee's Medicaid program evaluated patients who were enrolled into the

PRR program during the fourth quarter of 2010. An assessment of controlled substance use, which was measured immediately prior to and at least six months after PRR enrollment, demonstrated a 51 percent decrease in pharmacies visited, a 33 percent decrease in prescribers visited, and a 46 percent decrease in number of paid prescriptions among those patients enrolled in the PRR (n=96). From a 2014 report, Minnesota's Medicaid PRR estimated cost savings of $1.2 million in the first year of patient enrollment based on reductions in prescriptions, emergency room utilization, and clinic visits that resulted in an average savings of $4,800 per patient (based on projected enrollment of 245). Additional reductions in service utilization and costs were realized during the second year of program enrollment. In 2008, Oklahoma's Medicaid PRR reported decreases pre- and post- enrollment in the mean monthly average for narcotic claims (from 2.16 to 1.32), emergency department visits (from 1.26 to 0.81), number of pharmacies visited (from 2.05 to 0.89), and number of prescribers seen (from 2.48 to 1.63) for PRR patients with at least one month of eligibility in both the pre- and post- enrollment periods (n=52).

Outcomes information from commercial plans, including CVS Health and BlueCross BlueShield of Massachusetts, suggest that PRR programs could improve public health. An expert panel convened in 2012 by the Centers for Disease Control and Prevention concluded that these programs have the potential to save lives – and healthcare costs – by reducing opioid usage to safer levels.

PRRs in Medicare

PRRs have shown effectiveness in Medicaid and the private sector, but these programs are currently prohibited in Medicare. A statutory change will be required to authorize their use.

It is clear that substantial numbers of Medicare patients are at risk. A Centers for Medicare & Medicaid Services (CMS) analysis identified approximately 225,000 beneficiaries who received potentially unsafe opioid dosing (the equivalent of 120mg or more of daily morphine for 90 or more consecutive days).[ii]

A Medicare Payment Advisory Commission (MedPAC) analysis of 2012 prescription drug event data found that 12.3 million Medicare beneficiaries filled at least one prescription for an opioid, corresponding to about 36 percent of Part D enrollees and ranging from a low of approximately 23 percent in Hawaii to a high of approximately 50 percent in Alabama. Arkansas, Georgia, Kentucky, Louisiana, Oklahoma, and Tennessee were all at 40 percent or higher (see Appendix A). The vast majority of these individuals (87% of the 12.3 million) received the drugs for conditions not associated with cancer treatment or hospice care. In 2012, the beneficiaries with the highest use of opioids filled, on average, 23 opioid prescriptions at a cost of $3,500 per beneficiary.[iii]

Medicare beneficiaries are all too often getting opioid prescriptions from multiple providers. According to the same 2012 MedPAC analysis, among the subset of beneficiaries with the highest use of opioids for these indications, 32 percent obtained these prescriptions from four or more prescribers or three or more pharmacies. An evaluation of 2008 claims data conducted by the Government Accountability Office identified 170,000 Medicare Part D beneficiaries who visited at least five, and as many as 87, medical professionals in a year to obtain prescriptions for opioids or other drugs from 14 classes of abusable drugs.[iv]

Data from these evaluations highlight the need for PRR programs as a mechanism to achieve the balance of ensuring access to pain management while preventing overdoses and other harms associated with prescription drug abuse in the Medicare population.

The Stopping Medication Abuse and Protecting Seniors Act

In May 2015, Pew, along with health plan sponsors, managed care pharmacy providers and public policy organizations worked together to develop key principles that should be included in PRR legislation to ensure that these proposals provide patient protections while also ensuring that they work as intended to minimize potential harms from prescription drug misuse and abuse.[v] Patients in long-term care and hospice should be excluded from enrollment in a PRR. Beneficiaries should also have the ability to appeal their enrollment in a PRR. In addition, PRR program design should also allow for patient input on the selection of prescribers and pharmacies

to ensure reasonable access that considers geographic location, cost-sharing, travel time, and multiple residencies.

Pew supports the Stopping Medication Abuse and Protecting Seniors Act because it includes the key principles described above, to ensure both patient safety and access to care.

This legislation achieves an appropriate balance in allowing identification of doctor shopping and at-risk patients, and providing access to effective pain management. It includes the beneficiary protections outlined above and allows for broad stakeholder input on the development of criteria that will be used to enroll patients. The legislation also requires plan sponsors to contact the beneficiary's physicians prior to patient enrollment to verify whether the prescribed medications are appropriate given the beneficiary's medical condition. Beneficiaries will help select providers. An appeals process is also included. Finally, plans will be required to provide enrollees with information on resources to address prescription drug abuse, such as substance use disorder and addiction treatment services, when possible.

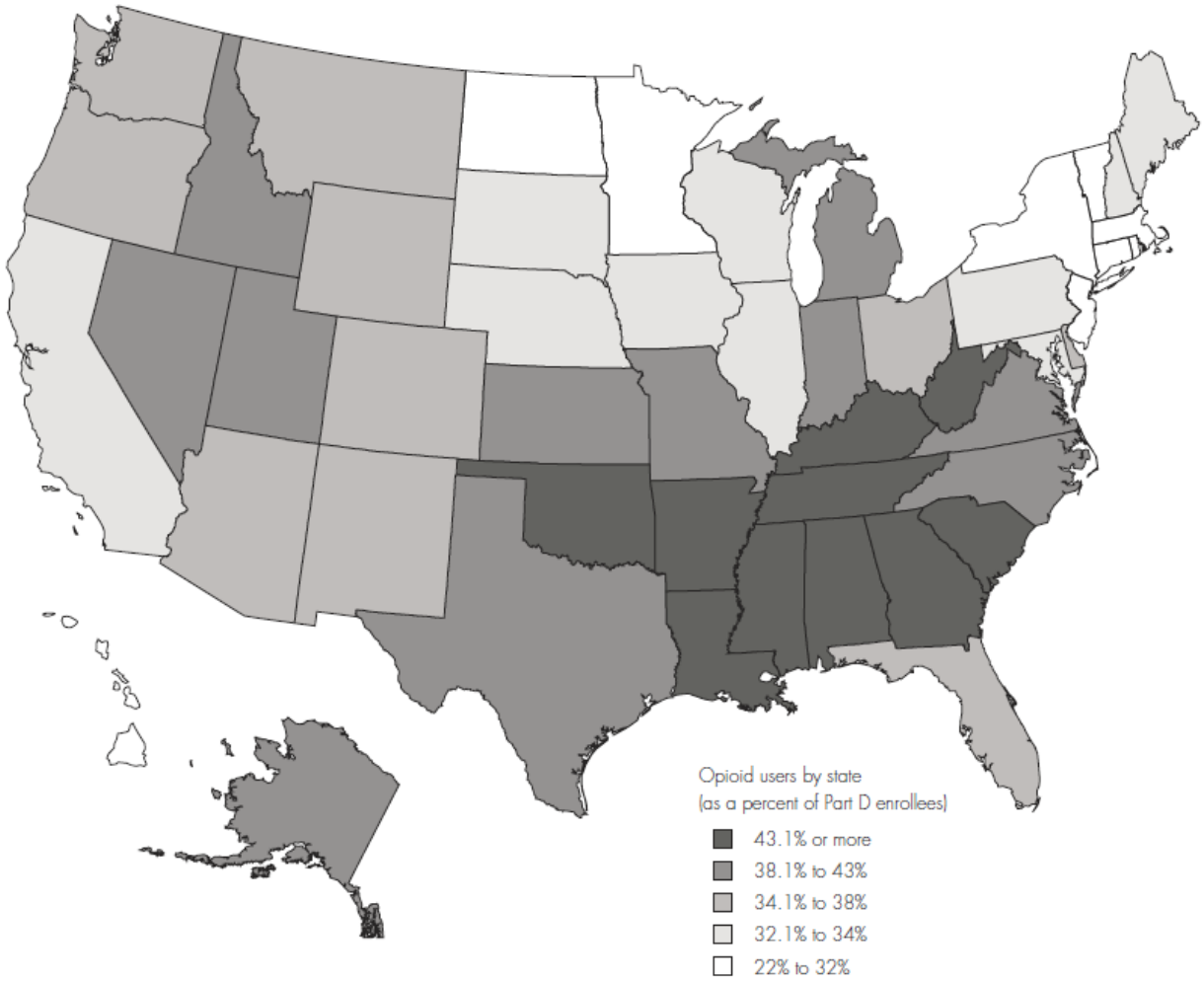
Support for the legislation

There is substantial support to advance the Stopping the Medication Abuse and Protecting Seniors Act as an effective tool to decrease opioid abuse and improve patient safety. A similar proposal has already passed the House of Representatives with broad bipartisan support as part of the 21st Century Cures Act, and President Barack Obama proposed this policy in his FY 2016 and 2017 Budget requests for the Department of Health and Human Services.[vi] The Office of the Inspector General also included PRRs in the 2015 Compendium of Unimplemented Recommendations as one of 25 quality improvements that should be prioritized and implemented.[vii]

We agree with CMS acting administrator, Andy Slavitt, who said a PRR proposal "makes every bit of sense in the world, and we completely agree that that's the kind of authority that would be very helpful in really taking a practical measure to stem abuse."[viii] Once again, we thank Senators Toomey, Brown, Portman and Kaine for introducing this legislation, as well as the many cosponsors of the legislation who sit on this Committee. We urge the Senate to help

address the nation's prescription drug abuse epidemic by passing the Stopping Medication Abuse and Protecting Seniors Act of 2015, which would expand use of the PRRs to ensure that these programs can be used to prevent prescription drug abuse in Medicare.

Appendix: Wide variation in use of opioids across states, 2012



Source: MedPAC analysis of Part D denominator and prescription drug event data.

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[i] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Compressed Mortality File 1999-2014. http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf

[ii] Centers for Medicare & Medicaid Services (2013), Supplemental guidance related to improving drug utilization controls. Correspondence from Cynthia G. Tudor, director, Medicare Drug Benefit and C and D Data Group dated Sept. 6, 2012. Available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/HPMSSupplementalGuidanceRelated-toImprovingDURcontrols.pdf

[iii] Medicare Payment Advisory Commission (2015) .Medicare and the Health Care Delivery System, Report to the Congress. Chapter 5. Available at http://www.medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0

[iv] Government Accountability Office (GAO) (2011) Medicare Part D: Instances of questionable access to prescription drugs," Report to Congressional Requesters. Available at http://www.gao.gov/assets/590/585424.pdf

[v] The Pew Charitable Trusts. Pew Urges Congress to Authorize Patient Review and Restriction Programs in Medicare, http://www.pewtrusts.org/en/research-and-analysis/speeches-and-testimony/2015/05/pew-urges-congress-to-authorize-patient-review-and-restriction-programs-in-medicare

[vi] 21st Century Cures Act, H.R.6, 114th Cong. (2015), Prescription Drug Abuse Prevention and Treatment Act of 2015, S.1431, 114th Cong. (2015); Department of Health and Human Services, "HHS FY2016 Budget in Brief" (2015), http://www.hhs.gov/about/budget/budget-in-brief

[vii] Office of the Inspector General, "Compendium of Unimplemented Recommendations" (2015), http://oig.hhs.gov/reports-and-publications/compendium/files/compendium2015.pdf

[viii] Healthcare Co-ops: A Review of the Financial and Oversight Controls. Senate Finance Committee Hearing, (2016) (statement of Andy Slavitt, acting administrator of the Centers for Medicare and Medicaid Services),

http://www.finance.senate.gov/hearings/healthcare-co-ops-a-review-of-the-financial-and-oversight-controls