February 16, 2018

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20515

Dear Chairman Hatch and Ranking Member Wyden:

At Molina Healthcare, Inc. ("Molina"), we are committed to ensuring high quality care for our members while decreasing the risk of beneficiary opioid dependence and addiction. Managed care organizations are on the front lines of the opioid crisis and we share the Committees' concerns about the increasing number of opioid-related overdose deaths and the millions of Americans suffering from prescription opioid or substance use disorders.

Molina has been serving the poor and underserved who are insured through government sponsored healthcare programs for close to four decades, engaging in Medicaid markets in thirty states and Puerto Rico. We have launched a successful business in the Health Insurance Marketplaces in seven states. In addition, Molina Healthcare has more Medicare-Medicaid Program (MMP) dually eligible individuals enrolled in our MMP plans than any other insurer in the country. We have been serving the neediest members of the Medicare Advantage program through our Dual Eligible Special Needs Program (D-SNP) product for close to a decade. Today, we are one of the ten largest health insurers in the country, serving more than 4.5 million low-income members in 12 states and Puerto Rico.

We are pleased to share our experiences and offer policy options to assist the Committee in its efforts to evaluate and address the impact of the opioid epidemic on government sponsored health care programs.

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 opioid use disorder (OUD) or other substance use disorders (SUDs)?**

Non-pharmaceutical treatments can be powerful tools in the treatment of pain, and the Centers for Disease Control and Prevention (CDC) cautions against opioids being first-line or routine therapy for chronic pain.[1] Despite state and federal initiatives and laws to reduce access to opioids, alternative

[1] https://www.cdc.gov/drugoverdose/prescribing/guideline.html

treatments remain unclear to many patients and providers. Through the Medicare and Medicaid programs, the Centers for Medicare and Medicaid Services (CMS) can take the lead on developing interdisciplinary approaches to pain management and innovative reimbursement initiatives and incentive structures that foster the use of evidence-based, non-pharmaceutical treatment options. Such an approach could allow for outcome based contracting aimed at individuals with chronic pain, or incentives to support primary care providers that deliver coordinated, interdisciplinary care to people suffering from chronic care. Proper treatment involves a team of providers and payment models should take into account the need for counseling and care coordination. These approaches foster closer partnerships between payers and providers, mutual assistance in care coordination and management, cooperation in data gathering and shared risk with an eye toward quality and outcomes.

CMS should also promote policies that further integrate the CDC's *Guideline's for Prescribing Opioids for Chronic Pain* (Guidelines) into practice. The Guidelines are simple and evidence-based and are geared toward curbing the risk factors associated with the development of an OUD. There should be efforts to match prescriber behavior with the Guidelines and to align financial incentives directly with performance. In 2017, America's Health Insurance Plans (AHIP) developed STOP (Safe, Transparent Opioid Prescribing Initiative), an initiative designed to support widespread adoption of clinical guidelines for pain care and opioid prescribing. As its first action under the STOP initiative, AHIP launched the STOP measure, an informatics tool health plans can use to measure how provider practices compare to the Guidelines.

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?**

Provider education is a barrier to non-pharmaceutical therapy for chronic pain that Molina is working hard to overcome. Molina launched a Pain Safety Initiative that encourages providers to utilize the CDC's *Guideline for Prescribing Opioids for Chronic Pain*. The Guidelines are a useful, initial step in encouraging providers to partner with their patients to deliver a safer, more effective pain management care plan. Molina has also been offering and supporting provider education in areas such as: opioid and naloxone prescribing; pain management; and the development of taper plans for patients on high opioid doses or combinations. Many of the resources allow for earning CME (continuing medical education) and include video webinars, online self-paced courses, and even mobile applications that providers can access on their phones or tablets to use at the point of care.

Molina supports increased efforts by CMS to continue building the evidence base for non-pharmaceutical treatments for pain and provide guidance to state Medicaid programs regarding best practices for covering these services. Non-pharmaceutical interventions are important tools in the management of chronic pain and while there is growing evidence to support the effectiveness of these and other non-pharmaceutical interventions, additional research is needed to better understand their role in managing pain.

Access is another barrier to non-pharmaceutical therapies for chronic pain. Insurance coverage affects clinical practice and different state Medicaid programs cover different therapies. CMS can take the lead in examining coverage and reimbursement for chronic pain therapies to align policy with the

evidence base and review and modify rate-setting polices that discourage the use of non-opioid treatment for pain.

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

Molina recommends the following changes to Medicare and Medicaid prescription drug program rules:

- Modify or suspend Ryan Haight Act as it relates to the treatment of opioid use disorders (OUDs) in rural areas. The Ryan Haight Act places restrictions on the practice of online pharmacies and the ability of practitioners to prescribe medications through the internet. Specifically, the Act requires an initial face-to-face visit by a telemedicine provider of MAT. This requirement limits access to care for people in rural communities with no access to MAT.

- Remove prior authorization requirements for accessing MAT across all programs. Medication therapies like buprenorphine can be prescribed by specially trained physicians, nurse practitioners, and physician assistants to treat the symptoms of withdrawal when a patient stops taking opioids; moreover, buprenorphine maintenance has been shown to save lives and decrease morbidity associated with OUD. However, prior authorization requirements often result in delays in treatment and represent a barrier to care access that is not supported by scientific evidence.

- Implement pharmacy and prescriber "lock-in" programs for patients using multiple prescribers. Facilitating coordination between physicians and pharmacies when patients are "doctor shopping" or "pharmacy shopping" is critical. We recommend implementation of regulations that allow health plans to limit filling non-emergency narcotic prescriptions to those written by in-network doctors and pharmacies only.

- Approve medical methadone maintenance treatment programs like Office-based Opioid Agonist Treatment (OBOT) for buprenorphine. According to the American Society of Addiction Medicine, despite its effectiveness, methadone maintenance treatment has been a significantly underutilized treatment modality in the U.S., and there are still places in the U.S. that bar its use altogether. OBOT treats opioid addiction as a chronic medical condition and therefore allows primary care physicians to provide addiction treatment services in their usual clinical settings, thus expanding the availability of care.

- Promote systematic coverage of Medication Assisted Treatment (MAT) in SBIRT (Screening, Brief Intervention, and Referral to Treatment) programs.

- Allow Medicare beneficiaries access to methadone in outpatient and physician settings. Currently, Medicare only covers methadone treatment for opioid addiction in inpatient hospitals. Since hospitalization is not always necessary for treatment, Medicare should also cover methadone treatment on an outpatient basis.

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

CMS should look to Massachusetts as a model for changing the way many medical professionals are educated about opioids. Medical schools in the state now require students to pass a core curriculum in opioid therapy and pain management. Molina supports policies like this one and others that incentivize residency programs to increase the number of SUD training/fellowships, and loan repayment programs for doctors willing to work in SUD and OUD underserved designated areas.

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

The Prescription Drug Monitoring Program (PDMP) has continued to evolve and in many states provides prescribers and pharmacists important information regarding prior prescriptions of controlled substances on people they are about to prescribe for or whose prescription is being submitted for fill. One of the gaps that diminishes the effectiveness of this tool is the lack of information sharing between states. Efforts should be made to allow for access to information from databases from other states to prevent people from obtaining scheduled medication from a state other than the one they live in without the ability for prescribers or pharmacists to access this data. This data should be available for integration into certified electronic medical record systems for ease of use.

Molina is currently in the process of developing a more robust Substance Use Disorder Dashboard, which aims to better quantify data and track trends to best identify what efforts are most effective to combat opioid misuse and substance use disorders. Using such a dashboard will also help us determine other areas that need more resources and how best to improve our fraud, waste and abuse efforts.

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

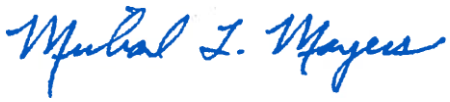
Molina believes that patient education efforts can be enhanced through federal efforts. We recognize that our members must be a part of the solution and actively engage them in our efforts. For example, we provide member education on opioid risk and offer member and family/caregiver education on naloxone. Several states have launched regional campaigns, such as the "Know the Risks" campaign in Northeast Ohio. The campaign is a collaborative effort among local agencies and organizations and includes news coverage, public service announcements, commercials, print advertisements and social media outreach on the risks associated with prescription opioids. We support the recommendation in the President's Commission on Combating Drug Addiction and the Opioid Crisis for the Administration to develop an evidence-based national education and awareness campaign to promote prevention and address the hazards of opioids.

Another state campaign, Make the Right Call, has helped spread awareness about the Massachusetts Good Samaritan Law. The law provides protection to individuals seeking medical assistance for

themselves or someone else experiencing a drug-related overdose, including opioid-related overdoes, and ensures the person will not be charged with possession of a controlled substance.

Thank you for your interest and we look forward to working with you to achieve effective, long-lasting results to combat the opioid epidemic. Molina Healthcare is committed to curbing the effects of the opioid epidemic on our members. Should you have questions or require additional information about our initiatives, please contact Amy Tenhouse, AVP of Federal Affairs at 202-639-9872 or amy.tenhouse@molinahealthcare.com.

Sincerely,



Michael L. Mayers
Vice President, Government Affairs