MAXIMUS Federal

February 16, 2018

Electronic Submission

Senate Committee on Finance
opioids@finance.senate.gov

ATTN: Mr. Orrin G. Hatch, Chairman
Mr. Ron Wyden, Ranking Member
opioids@finance.senate.gov

RE: Effort to Provide Relief from the Scourge of the Opioid Epidemic.

Dear Chairman Hatch and Ranking Member Wyden:

MAXIMUS Federal Services Inc., (MAXIMUS Federal) is pleased to provide our response to your letter dated February 2, 2018 to provide our suggestions related to combating the opioid crisis. The complexity of the opioid crisis and the ever increasing scope of the crisis, requires medical, legislative, behavioral, education and legal changes that are coordinated across federal, state and local governments. This is a multifaceted crisis that must be addressed by national and community based systems approach beyond just silo approaches to:

- Prescribing practices
- Naloxone distribution
- Access to treatment
- Diversion and recovery

We offer the following specific suggestions in accordance with the questions posed.

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 (SUD)?**

Avoiding exposure to opioids is the optimal way to avoid and prevent dependence and addiction. Therefore, payment incentives for promoting evidence based alternative treatments to opioid pain treatment include an analysis of the available literature, support of studies to produce sufficient evidence, and adopting payment policies that expand coverage for non-opioid treatment for pain. These incentives will have a significant impact. Once coverage is expanded for non-opioid treatments through Medicare and Medicaid, provision of these non-opioid treatments can be tracked through claims data. Additionally, use of a modifier for non-pharmacologic treatments will assist with the creation of incentives for providers. (See Appendix A for lists of articles that promote evidence based non-pharmaceutical approaches.)

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?

Due to the lack of evidence-based literature for many non-pharmacologic treatments for pain, Medicare and Medicaid policy typically excludes the coverage of modalities such as acupuncture, biofeedback (including neurobiofeedback), magnet therapy, massage, and other treatments considered "alternative" or "complementary" for pain and/or depression that accompanies chronic pain. Additionally, integrated healthcare practices and Functional Medicine providers embrace non-pharmacological pain management treatments and address the mental health issues that accompany pain. As mentioned above, removing barriers can be accomplished through analysis of the available literature, supporting studies to produce the evidence, adopting payment policies that cover non-pharmacologic treatment for pain by these providers and integrating the mental health aspect of pain into care.

Integrating the non-opioid modalities and/or including providers that deliver the non-pharmaceutical approaches can assure that the provider is educated on new treatment modalities that are available and are covered services. Professional societies should take responsibility and support the educational piece of non-pharmaceutical alternative treatments. Agencies such as the CDC, CMS, NIH, FDA and SAMHSA can also support education efforts in a collaborative manner.

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?

It has been recognized for a number of years that mental health issues are present in up to 40% of patients seen in a primary care setting (AAFP, 2011). Additionally, many patients with mental health issues receive either no mental health treatment or mental health treatment in the medical setting as opposed to a mental health setting (Huskamp & Iglehart, 2016). Pain, both acute and chronic, often is correlated with mental health issues such as depression, anxiety, and other physical issues as well. Chronic pain is a large contributor to unemployment and disability. Those suffering from chronic pain and disability are at risk for development of mental health issues.

Another obstacle is that traditionally, mental health and substance abuse treatment(s) were either carved out of or not adequately covered by health insurance in both the public as well as the private sector. It is well known that using drugs, including opioids, can be a result of self-medicating for individuals that have mental health disorders. The high correlation of dual diagnosis for substance use and psychiatric disorders requiring monitored treatment is further support for integrated healthcare models (Help Guide, 2016). Mental health issues have carried a stigma in society for several years which is diminishing over time as there is a growing focus on recovery for individuals with mental illness (Rosenbaum, 2016). Having the presence of mental health providers and information available in a primary care setting will help to "normalize" those once tabooed topics.

Other social determinants also play a role in the response to treatment. Integrated models of care have evolved over the past several decades to address the issue of how to approach the entire spectrum of needs for each individual. However, despite attempts to find the model(s) with the best outcome(s), there still exists a lack of optimal mental illness treatment in the coordination of care efforts. These factors have contributed to a fragmented health system. With little coordination between mental health, substance abuse, and physician prescribing of opioids, we are now dealing with the results of this fragmented healthcare system. Furthermore, the economic and employment impact of opioid abuse is well documented and, yet there is little if any coordination between employment and housing services which are fundamental to ensuring recovery from a substance abuse disorder. Strengthening supports for public housing providers to avoid eviction when residents are amenable to treatment for opioid addiction and utilizing Medicaid to reimburse supportive housing programs that co-locate employment, education and health services would be greatly beneficial.

Access to psychiatric care is another contributing factor for this divide (Huskamp & Iglehart, 2016). Examining local appointment availability for adolescent psychiatry services in our community revealed a ten week wait for access to an adolescent psychiatrist. With this gap in access to care, it can be concluded that needed mental health and medical care is not optimized when the services of a psychiatrist are needed. In the case of a psychiatric condition with comorbid substance use, this may escalate the self-medication that commonly occurs in this population.

4. 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?

Frequently, the elements of this edit are not included in the Health Plan Management System (HPMS) prior authorization criteria and plans fail to submit accurate and complete case files and relevant information for the appeal process. The right of appeal provides opportunity for inappropriate and fraudulent submissions on part of the enrollee or prescribing physician. In order to address this issue, mandate submission of primary source medical record documentation to substantiate any prescriber statement.

In order to minimize the risk of developing OUD and SUDs, there can be changes to the Medicare/Medicaid prescription drug programs including pre-authorization prior to receiving a prescription, step-wise therapy that documents the trial of non-opioid treatment first and rules limiting the quantities of opioids prescribed (see Appendix A, WV and Ohio BWC). One area that presents challenges to these changes stems from individual state prescribing rules that govern provider prescribing behavior. Adopting federal or national guidelines without the variance of state requirements may streamline the process by requiring only one set of regulations.

5. How can Medicare or Medicaid better prevent, identify and educate health professionals

This education needs to start in the medical school curriculum and continue throughout one's career. Medicare and Medicaid funding of residency programs or payment made to residency

programs can carry requirements that promote education in the area of non-opioid treatment of pain.

For those individuals with high prescribing patterns, swift and strict sanctions need to be implemented and enforced. One example of many is the case of one physician who reported a colleague for highly inappropriate opioid prescribing resulting in significant morbidity and mortality, and the State Medical Board took five years to sanction the inappropriate prescriber. Taking enforcement out of the State Medical Board's hands (where there are physicians presiding) and placing responsibility on law enforcement to take swift action will result in less inappropriate prescribing.

In order to prevent and identify high prescribers, Medicare and Medicaid can readily identify providers that are outliers both in total quantity prescribed but also in percentage of patients in the practice receiving prescriptions. Additional data analysis can examine diagnosis and procedure codes to determine the appropriateness of prescribing. Policy can address coordinated efforts between Medicare and Medicaid and the Drug Enforcement Agency (DEA) suspending or revoking controlled substance prescribing privileges for suspected over-prescribing. Education of high prescribing providers can be achieved through mandatory education in order to maintain inclusion in federal program participation.

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

MAXIMUS has the unique perspective for collective prescription drug data sharing in the country of Canada where it controls and manages the operation of a nationwide shared database that monitors prescription drug utilization. This experience reinforces the need for National data sharing between Medicare, Medicaid, Department of Veterans Affairs (VA), and Tricare to limit access to excessive medication provided it is required to search the database prior to administration and any appeal process takes into account these entries. Prescription Drug Monitoring Programs (PDMP) can help curb excessive and inappropriate prescribing. State continuity on requirements for checking the database, and State access to the data for utilization reviews, would assist in strengthening the program. HHS should support efforts to integrate PDMP data into the broader health care system across all publicly funded health care.

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?

States and the military have successfully incorporated acupuncture and holistic services to reduce the need for opioids. In addition, dual diagnosis focused treatment for substance abuse and mental health disorders have been proven to be much more effective but the key to these programs is providing ongoing supportive services throughout recovery. (See Appendix A). Substance use disorders are chronic conditions that are not treated with a single intervention. Multi-modal services need to be available to support individuals through their recovery.

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

The toll of the opioid epidemic is being felt by the family members who care for children whose parents are addicted. Several states have piloted innovative approaches that have shown a reduction in opioid use and the ability for children to maintain or return to their parents' care. For example, the Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) program promotes child safety and family well-being by streamlining and coordinating child welfare services, treatment services and actions by the courts overseeing the children and parents. Ohio has implemented Family Dependency Treatment Courts. Family drug courts are among the most effective programs for inducing parents to enter and complete substance abuse treatment, improving other outcomes and saving public funds. By design, parents in family drug courts have greater participation in drug treatment programs compared to participants in traditional courts, resulting in higher treatment costs. But, the overall savings due to reduced use of foster care, the courts, jails and probation officers is substantial.

Combining Medication Assisted Treatment (MAT) with cognitive behavioral therapy has been shown to be much more effective than MAT alone. Patients who participate in behavioral therapy combined with the appropriate MAT have a long-term recovery rate of at least 50 percent, on par with chronic, relapsing diseases such as diabetes and hypertension. Unfortunately, the impact on children whose parents abuse opioids places them at risk for a myriad of social, educational and developmental challenges. Early intervention to address this chronic disease can reduce long term child welfare costs.

Thank you for your efforts to tackle this most vexing challenge facing all American communities.

The following individual is available and authorized to discuss the enclosed materials on behalf of MAXIMUS Federal.

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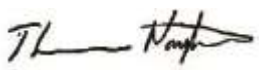
Sincerely,



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Appendix A

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- Curthoys, K. (2018, February 4). Army working on more ways to manage soldiers? pain in the fight against opioid abuse. Retrieved from https://www.armytimes.com/news/your-army/2018/02/02/army-working-on-more-ways-to-manage-soldiers-pain-in-fight-against-opioid-abuse/. This article discusses how the U.S. Army is reducing the risk of opioid use for pain management. One of the solutions is the use of alternative medicine treatments in Integrated Pain Management Programs which includes Acupuncture, Yoga, Chiropractic, and other services. The Army has reported a 19% drop in opioid use with these programs.
- West Virginia SB273 | 2018 | Regular Session. (n.d.). Retrieved from https://legiscan.com/WV/text/SB273/id/1687476. West Virgina law to limit opioid prescription to 7 day supply. ER, Dentists, and Optometrists are limited to a 3 day supply.
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