ALTARUM

SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

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The Honorable Orrin G. Hatch
Chairman, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Hatch:

Altarum is committed to fighting the national opioid epidemic. Our recent research shows the economic toll of the opioid crisis in the United States has exceeded $1 trillion since 2001.[1] The Medicare population has not been spared, with more than 6 of every 1,000 beneficiaries diagnosed with an opioid use disorder. For Medicaid beneficiaries, the prevalence of diagnosed opioid use disorder is even higher, at 8.7 per 1,000 – 10 times higher than in populations who receive coverage under private insurance companies.

For more than 20 years, Altarum has been at the forefront of efforts to address behavioral health issues in the U.S., particularly those related to addiction, treatment and recovery; opioid use and abuse; continuing integration of mental health and addiction service systems; and the concurrent integration of behavioral health with physical health systems under the Patient Protection and Affordable Care Act (ACA).

Our partners and customers have implemented effective and affordable care coordination services for people with addictions; expanded provider networks while increasing capacity for faith-, community-, recovery-, and culturally-based organizations; implemented continuing medical education (CME) programs to increase behavioral health screening within primary care; implemented CME provider education to support patient safety and responsible opioid prescribing; and developed innovative payment and delivery system reform efforts in Medicaid and commercial insurance.

We also are working to advance systems of care that promote empowerment and choice, foster resilience, and facilitate mental health and addiction recovery for individuals, families, and

[1] https://altarum.org/about/news-and-events/economic-toll-of-opioid-crisis-in-u-s-exceeded-1-trillion-since-2001.

communities. Through the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Community and Faith-Based Organization Technical Assistance Project, Altarum provided technical assistance and training to grassroots faith and community-based coalitions to build capacity to support a network of substance use recovery services. Finally, Altarum developed and implemented a CME program to train primary care providers and help them provide depression screening, counseling, and referrals in the primary care setting.

Given our experience in behavioral health, we provide the following answers to your questions.

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?*

Achieve higher participation in Advanced Alternative Payment Models (AAPMs) by building on CMMI's experience with the Bundled Payment for Care Improvement (BPCI) initiative, and moving beyond the newly announced BPCI Advanced model.

Most health care continues to be paid fee-for-service, despite the efforts of CMS to implement alternative payment models. As it has been well documented for decades, the fee-for-service system encourages care fragmentation and overuse of low-value care services. At its extreme, it can create an incentive for patient harm by providing increased revenue when that harm is incurred.

On the other hand, alternative payment models, whether bundled payments or total costs of care, encourage a more comprehensive view of patient care and a more judicious use of health care resources. In these models, hospitalizations for OUD or other SUDs becomes an expensive and avoidable added cost. Similarly, excessive use of prescription pain medication is discouraged in favor of evidence-based alternatives. For example, physicians and hospitals engaged in joint replacement bundled payment programs have started to develop new and accelerated recovery treatment, getting the patient to move soon after surgery, to reduce the dependence on pain medication and improve post-operative recovery.

While the national Health Care Payment and Learning Action Network recently reported that 30 percent of care is now paid for under alternative payment models, the pace of change has to be accelerated. To date, most of Medicare's emphasis on payment reform has been centered on hospital or hospital-based systems. Yet, physician decisions over the utilization of office visits, prescriptions, lab tests, images, and hospital stays influences 88 percent of the total spend. Though physicians control or have influence over most of Medicare's dollars, only 16 percent of the total Medicare spend (Parts A, B and D) is represented by the current physician fee schedule. And in less than 10 years, the Congressional Budget Office (CBO) projects this figure will dwindle

to 12 percent. This non-alignment is profound, especially since physicians have the ability to best manage unwarranted variations in costs and outcomes of conditions and procedures.

Further, an increasing number of clinicians are employed by hospital systems and large group practices. These clinicians may not be as directly involved in decisions made by their organization to form or join an Advanced APM. However, independent clinicians and clinicians in small groups still make up a substantial portion of the workforce and may require special attention to encourage, accelerate, and ease their participation in Advanced APMs. Finally, the long term success of AAPMs in re-shaping the delivery system to better meet the needs of patients cannot be achieved—especially for high need patients—without the active collaboration of community-based organizations and support services. Encouraging the sharing of financial gains achieved by the better management of patients to organizations outside the walls of medicine requires a special focus.

While Accountable Care Organization (ACO) APMs play an important role among AAPMs as a whole, Altarum believes CMMI should give greater consideration to an episode of care model that is open to all provider configurations that have the ability and willingness to take risk. Further, CMMI should allow providers to specialize in the areas they feel they are best positioned to compete.

Acute care bundles in the hospital setting are important, but not as important as managing specialty condition episodes in an outpatient setting. We believe the Innovation Center already has access to some of the tools it needs to innovate policy for payment reform, and one of them is the Episode Grouper for Medicare (EGM).

In 2012, CMS awarded a contract to Brandeis University to develop EGM in association with the American Medical Association-convened Physician Consortium for Performance Improvement (AMA-PCPI), the American Board of Medical Specialties Research, and Altarum. The importance of EGM is that it would allow CMMI to adopt a non-DRG model—which is biased towards hospital systems—for provider episode of care contracting, and open up participation in two ways: 1) by incorporating a wider array of provider organizations, including physicians, and 2) by placing an emphasis on the condition episodes into which most of Medicare's dollars are flowing and where physician care teams are able to best improve care and lower costs. In early 2017, Brandeis and the American College of Surgeons advanced a model that leverages the EGM and opens up a number of episode of care APMs for a large portion of the health care system. That model has been recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for pilot testing, and we strongly encourage CMMI to aggressively pursue such an implementation.

Provide incentives to advance responsible opioid prescribing, and support Medicare and Medicaid providers through robust clinical education, training and technical assistance.

Many clinicians struggle with patient pain management, and are not prepared to initiate safe pain management therapies. This includes opioid prescribing, even when warranted. Providers lack education, training, and tools to perform appropriate risk assessment, prescribing, and monitoring to prevent opioid dependency or misuse. Responsible opioid prescribing must be addressed to increase provider comfort and confidence utilizing evidence-based tools to address beneficiaries' substance use risks.

Altarum has developed and implemented a comprehensive program to tackle the national opioid crisis at the source—by equipping clinicians with the knowledge and tools necessary to foster responsible opioid prescribing, improving patient education around opioid use, and delivering technical assistance to promote use of prescription drug monitoring programs (PDMPs).

The majority of policy around pain management impacting opioid prescribing is enacted at the level of state government, with nearly half of all states requiring continuing education for prescribers. While mandates for provider level education can result in a decreased rate of opioid prescribing, they may also result in unintended consequences on patient pain, or overdose deaths associated with the decreased availability from under-prescribing. Thus rather than mandates, we propose CMS implement incentives for provider education. For example, in addition to reimbursement that is already in place for substance abuse screening, brief intervention, and referral to treatment (SBIRT), we suggest CMS reimburse clinicians for their time associated with participating in robust and ongoing clinical medical education (CME) and Maintenance of Certification (MOC) programs that provide training for patient screening, detecting risks and providing follow-up for at-risk beneficiaries. Furthermore, we propose that these programs should be provided at no cost to clinicians.

Modify the Merit-based Incentive Payment System (MIPS) to engage and reward clinicians who are prescribing opioids.

The Merit-based Incentive Payment System (MIPS) allows participating clinicians to earn a payment adjustment based on evidence-based practice and quality specific data. Within MIPS, there are approximately 270 performance measures; however, only three are opioid-related measures:

- Documentation of Signed Opioid Treatment Agreement;
- Evaluation for Risk of Opioid Misuse; and

- Opioid Therapy Follow-up Evaluation.

Currently clinicians can choose from the full measure set to identify at least six measures for quality reporting. There are also two opioid-related practice activities: 1) Consultation of a prescription drug monitoring program (PDMP); and 2) Completion of training to provide opioid medication-assisted treatment. MIPS is an ideal tool to continue to encourage and reward positive provider performance. Altarum supports expanding MIPS to included additional improvement activities, including participating in continuing medical education for opioid prescribing. Further, in order to meaningfully address reducing the risk for beneficiaries, we propose that CMS provide an additional incentive for clinicians who voluntarily choose to report an opioid related quality measure, i.e., raising the MIPS score and clinician reimbursement for these providers

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?*

Provide increased reimbursement for non-pharmaceutical and non-interventional pain management. Non-pharmaceutical therapies are time consuming and not the first-line for pain management.

Opioids are widely accepted as effective for acute pain and for cancer or in end-of-life. However, evidence indicates that non-pharmaceutical therapies also are of great benefit for chronic pain. We suggest that CMS support additional research on safe and effective treatments for chronic pain including non-pharmaceutical treatments, which tend to be more time-intensive and less-well reimbursed. For treatments such as physical therapy, psychological counseling, chiropractic/osteopathic manipulative treatment, massage, and cognitive behavioral therapy to become mainstream, CMS should continue to move from fee-for-service payments to AAPMs, and include quality measures associated with the use of alternatives to pharmaceutical therapies. Further, physicians need to be retrained on first-line therapies, as mentioned in the prior section.

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?*

Encourage the development of physician specialty alternative payment and delivery system models.

The poor outcomes and high spending experienced by patients with complex or chronic medical conditions is often exacerbated by having unmet social needs. For example, a Commonwealth Survey found that among high-need adults (those with two or more major chronic conditions, including SUD/OUD and Mental Health or Behavioral Health conditions), 62 percent had a material hardship (difficulty paying for housing, utilities, or food), compared to 32 percent of non-high-need adults[2]. Strong evidence suggests that integrated care teams composed of social workers and community health workers, for example, can produce better quality and savings when working in conjunction with the medical care team to provide customized approaches for high need patients.[3] When testing care teams headed by a specialist, we encourage side-by-side evaluation of other team heads (primary care provider, nurse coordinator, community health worker), as the savings seem to be largely derived from upstream interventions.

We also recommend developing screening tools for customize care plans for patients with high needs. There is robust evidence that these interventions should be highly targeted and customized to the patient population, suggesting that tested screening tools will be integral to realizing the best possible outcomes. At present, there is disparate use of these tools (although CMS has made an initial effort to create a standard). Rigorous evaluations of the patient screening tools currently in use, and wide dissemination of results, would be of great help to designing and implementing these types of models.

Expand New York State DSRIP-Like programs.

In New York State, the DSRIP program includes a powerful incentive for Medicaid Managed Care Organizations (MCOs) to adopt and implement value-based payment (VBP) programs similar to CMS' AAPMs. To enforce the contracting of VBP programs between MCOs and their network, the state of New York uses a rate setting mechanism. New York's MCOs have specific target volumes for payments to providers that must be converted to VBP in order to avoid cuts in rates set by the state for their plan. With this policy in place, the state of New York is more likely than others to achieve the goal of converting the vast majority of Medicaid payments to providers from FFS to VBP.

An analysis of 2015 New York State Medicaid data shows that 20 percent of all costs are directly

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[2] Abrams, Melinda, et al., How High-Need Patients Experience Healthcare in the United States, The Commonwealth Fund, Washington D.C. (December 2016).

[3] http://www.healthcarevaluehub.org/files/6714/9909/2950/Hub-Altarum_RB_17_-_Addressing_Needs_of_Complex_Patients.pdf.

attributed to beneficiaries with a combination of mental health, behavioral health, substance use disorders, and related co-morbid conditions[4]. Of those, 50 percent are caused by inpatient stays and another 20 percent by emergency department (ED) visits. For patients who have a combination of conditions, the hospitalization and ED visit rates, respectively, are 300 percent and 500 percent greater than for beneficiaries without any of those conditions, illustrating the importance of improving the overall care for these populations. Further, the growing opioid epidemic continues to not only have high societal costs, but a significant economic impact. According to an analysis by the National Center for Injury Prevention and Control, spending for health care and substance abuse treatment for those abusing opioids was over $28 billion and costs for those with untreated opioid use disorders (OUD) incur approximately $18,000 more in health care costs annually than those without OUD. The types of VBP models that are being implemented in NYS have a focus on bringing together the care of high needs patients under an integrated payment and delivery system model that includes a variety of foci and takes into consideration the importance of community based organizations in the recovery of patients.

The opioid overdose epidemic in the U.S. is driven largely by unsafe opioid prescribing,[5] misalignment of incentives that prevent better prescribing practices, and lack of integrated technological systems that enable the identification of high prescribers. Approximately 23 states require medical prescribers to receive pain management training centered on controlled substance prescribing, and substance use disorders.[6]

Altarum has developed and implemented a comprehensive program to tackle the national opioid crisis at the source—by equipping clinicians with the knowledge and tools necessary to foster responsible opioid prescribing, improving patient education around opioid use, and delivering technical assistance to promote use of prescription drug monitoring programs (PDMPs). We suggest programs provide direct training, technical assistance around prescribing, and promote primary and behavioral health care integration with special attention to opioid misuse and abuse prevention services (e.g., opioid alternatives, patient screenings, and referrals). These programs provide an important solution, addressing the gap in prescriber training to improve safe opioid prescribing.

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[4] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf.

[5] Davis, C. S., & Carr, D. (2016). Physician continuing education to reduce opioid misuse, abuse, and overdose: Many opportunities, few requirements. Drug and Alcohol Dependence, 163, 100-107. doi:10.1016/j.drugalcdep.2016.04.002.

[6] http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/.

Bundled payment packages present an opportunity to lower the cost of treatment, engage patients in their care (including linkage to recovery supports) resulting in a comprehensive clinical approach that will lead to improved health outcomes. It also has the potential to create a new culture regarding substance use disorder and transform the system of care delivery.

Traditionally medical clinicians and substance use disorder treatment providers have been reimbursed for specific services rendered during multiple face-to-face patient visits rather than using an outcomes-based approach[7]. Other factors lead to disjointed and fragmented financial structures that hinder patient-centered care and increase the administrative burden and thus the cost of substance use disorder-specific care. There is a value opportunity as it relates to medical cost in a bundled payment structure. It is widely accepted that untreated or ineffectively treated behavioral health conditions, like substance use disorder, lead to increased medical treatment and associated costs, not increased behavioral health care costs. With a bundled payment structure, a patient's substance use disorder needs can be more thoughtfully discussed and coordinated, to include recovery support providers and access to other, lower cost, community-level interventions.

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?*

Limit the length of initial opioid prescriptions.

The length of an opioid prescription is a significant predictor of continued opioid use regardless of whether the medication is needed.[8] Thus, Altarum supports CMS' recent proposal on limits on initial prescribing for opioids for Medicare Enrollees and "hard formulary levels" at pharmacies. [9] We also encourage state legislation imposing a limit of a seven-day supply of opioid medication for first-time adult patients, and no more than a seven-day supply to minors.

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[7] Miller, Davis, Melek, Kathol, & Gordon (2017). Payment Reform in the Patient-Centered Medical Home: Enabling and Sustaining Integrated Behavioral Health Care. American Psychologist: 55-68
20 Maragakis, Siddharthan, RachBeisel, & Snipes (2016). Creating a Reverse Integrated Primary and Mental Healthcare Clinic for Those with Serious Mental Illness. Primary Health Care Research & Development: 421-427.

[8] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA. 2016;315(15):1624–1645. doi:10.1001/jama.2016.1464.

[9] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-02-01.html.

Tie clinician reimbursement to registration and utilization of the State Prescription Drug Monitoring Program (PDMP).

The use of three or more prescribers within a three-month period is associated with a seven-fold increase in risk of fatal opioid overdose and those with a concurrent prescription for opioids and benzodiazepines results in a four-fold increased risk of opioid-related death.[10] PDMPs effectively reduce doctor shopping and diversion of controlled substances by collecting prescription and dispensing data prescribed which are made available to authorized users. The number of states with policies on registration and required use of PDMPS is increasing.[11] We support CMS' continued efforts to link payments to quality and value, and suggest that encouraging the enhancement and use of state PDMPs will be an important method to encourage responsible clinician prescribing. Specifically, we propose reimbursement for clinician trainings that include teaching participants how to effectively use state Prescription Drug Monitoring Programs (PDMPs)—which will enable clinicians to integrate the use of the PDMP into their workflow, appropriately monitor new opioid prescriptions, and access patient history to identify potential patterns of misuse.

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

Provide incentives for education, technical assistance, and enabling technology to change opioid prescribing patterns.

Beyond policy being in place that requires health care providers to adopt the use of Prescription Drug Monitoring Programs (PDMPs), adequate resources that support the meaningful adoption of PDMPs into the clinical workflow will improve prescribing patterns. Medicaid and Medicare programs need to be able to identify health care providers that are high prescribers to direct education and training support to providers that need it most.

For example, physicians who are employed by a health system already have their prescribing habits monitored. This allows individual health systems to deploy timely interventions to reduce unsafe prescribing habits. States need more support by way of prescribing data at the per-provider level to reach providers that are independently operating outside of a larger entity, e.g., health system.

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[10] http://www.namsdl.org/library/Congressional%20Briefing%20-%20Final%20Agenda%20and%20Presentation/.
[11] http://www.namsdl.org/prescription-monitoring-programs.cfm.

This in turn would activate an upstream approach to reduce the negative impact that unsafe prescribing habits have on patients, families, and communities.

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

Create interoperability standards for prescription drug monitoring program s to enable a consistent method for accessing data.

Forty-nine states have PDMPs; however, only about half of states share PDMP data with other state PDMPs as well as authorized users.[12] To encourage PDMP interoperability we support creating a standard FHIR resource and HL7 message standard that would enable outside systems a standard way of accessing PDMP data. This interoperability will allow state PDMPs to be more easily accessed and analyzed and used in other applications.

Currently, each PDMP interface is a one-off development effort, not usable or applicable for other applications and uses. CMS can provide critical startup support by helping create the data and organizational infrastructure to support the state's multi-stakeholder efforts. Specifically, the absence of timely and reliable data limits their ability to identify healthcare cost drivers, poor-quality hot spots (e.g. high volume prescribers and frequent utilizers) and whether or not interventions are effective. We suggest CMS provide support in the form of state grants and accompanied by technical assistance so that states benefit from efforts already underway. Additionally, we suggest robust objectives defining the role that the data play, data transparency, and how it will lead to specific, evidenced-based actions to create an affordable, accessible healthcare system that puts patients first.

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?*

Create integrated care teams comprised of medical and community providers.

An analysis of 2015 New York State Medicaid data shows that 20 percent of all costs are directly attributed to beneficiaries with a combination of mental health, behavioral health, substance use disorders, and related co-morbid conditions. Of those, 50 percent are caused by inpatient stays and another 20 percent by emergency department (ED) visits. Reducing these potentially

[12] http://www.namsdl.org/library/CAE654BF-BBEA-211E-694C755E16C2DD21/.

preventable events could significantly reduce overall costs of care.

Screening for Substance Use Disorders (SUD) can take place as part of a complete history, or within a brief office visit. However, most primary care providers do not feel prepared to diagnose a substance use disorder, and as mentioned above many indicate they lack the adequate training to do so. CMS will need to prepare providers for integrated mental and physical health systems including collaboration between primary care and behavioral health providers in the community (e.g., training for primary care providers to screen for depression, and potentially using telehealth to increase access to behavioral health services in rural areas).

Strong evidence suggests that integrated care teams that include social workers, community health workers, or other providers designed to address unmet social needs in conjunction with the medical care team can produce better quality and savings. Yet, to be successful, they must employ a highly targeted, customized approach for these high-need patients. Many states are implementing solutions that build primary care providers' capacity to identify and treat substance use disorders while also strengthening their primary care systems' connection with specialty substance use disorder treatment providers across the continuum of care. If care teams headed by a specialist are tested, we encourage side-by-side testing of other team heads (primary care provider, nurse coordinator, community health worker) as the savings seem to emanate from the upstream, non-acute interventions provided to the patient.

Link individuals in recovery to systems of care.

Our nation's opioid epidemic is particularly devastating for those experiencing homelessness and disconnection from social supports. Reverse behavioral health integration shows promise as a way to expand treatment access and improve the patient experience, resulting in improved outcomes and lower cost to the health care system.

Reverse behavioral health integration occurs when primary care services (including behavioral health) co-locate or are made available at alternative sites outside of a health center. Washington State's Recovery Café model is an opportunity for reverse integration and treatment expansion. The Recovery Café is an alternative, therapeutic, and supportive community, providing a range of recovery and social supports to individuals traumatized by homelessness, addiction, and mental health challenges. It is derived from an evidenced-based ecological model, Recovery Oriented Systems of Care (ROSC).

A ROSC is patient-centered in that it meets individuals where they are on the recovery continuum, engaging them for a lifetime (as with other chronic conditions), and addresses other social determinants of health. Patients of the Recovery Café see improvements in terms of sustained

recovery, housing access, and linkages to social and health services, education, and employment opportunities. Patients also avoided overdose and decreased illicit substance use.

The model presents an innovative opportunity to connect individuals to primary care. Several times a week a care team consisting of a physician, nurse, behavioral health provider, and care coordinators can visit the café to provide integrated services. Behavioral health providers offer group and individual therapy. Care Coordinators address social determinants including shelter, employment, and food security. In terms of funding, this model would be Medicaid reimbursable while expanding primary care and behavioral health access.

Employ virtual "Healthy Recovery Lifestyle Coaching."

There is mounting evidence that the increased uses of mobile health (mhealth) approaches have promise as an intervention to reduce substance use.[13] Behaviors and activities consistent with healthy lifestyles have been shown to sustain longer-term recovery outcomes. Healthy lifestyle coaching, with a recovery context, is an intervention that can encourage specific behaviors, help an individual work toward defined personal recovery goals, ultimately maintaining recovery and an overall healthy lifestyle. Structural and other barriers in the life of an individual in recovery may prevent participation in in-person healthy lifestyle interventions. Thus, virtual health recovery lifestyle coaching is an intervention that can provide much-needed lifestyle coaching while responding to in-person participation barriers.

In a virtual healthy recovery lifestyle coaching intervention (similar to a model implemented by Aetna's Active Health Management program), the individual choses the healthy changes on which they would like to work. It offers a combination of virtual coaching by a trained coaching professional, with substance use recovery experience, complemented by tools that can further support healthy lifestyle choices. Individual or group coaching is available. Individual coaching provides personalized attention, focused specifically on the individual's recovery or healthy lifestyle specific needs, strengths, and barriers. Group coaching facilitates peer support and inspiration in that the individual is surrounded with people who are committed to similar goals. Group coaching sessions happen via group text messages, closed social media pages, or through shared email exchange. Ideally, the virtual program is connected to an online portal where there is easy access to online peer support and other self-guided resources, 24 hours a day, 7 days a week.

[13] Kazemi et al. (2017). A Systematic Review of the mHealth Interventions to Prevent Alcohol and Substance Abuse. Journal of Health Communications: 413-432.

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?*

Invest in Recovery Community Organizations, and innovative programs, such as peer recovery coaches in emergency departments.

Approximately 12 percent of children in the U.S. lives with a parent who is dependent on or abuses alcohol or other drugs. Yet the percentage of parents who receive support services is limited, and many parents who initiate treatment do not complete it. Thus, it is imperative that human service programs work to both prevent and mitigate the long-term impacts that substance abuse has on both children and families.

There are a collection of community services that can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use. These services include recovery schools, peer-led programs, recovery coaching, mutual aid groups, housing, education, employment and social resources. CMS should examine innovative programs, such as deploying peer coaches in emergency departments, community outreach teams to recognized overdose hotspots, and counselors to provide recovery support through phone calls and text messages. Peers also have joined law enforcement to help engage those struggling to obtain necessary services.

Recovery support is currently delivered by independent, nonprofit local groups called Recovery Community Organizations and other peer-led programs. These often small, under-resourced groups need to grow and expand so they can respond to the unprecedented level of need our country is currently experiencing. It is crucial that we fund the recovery part of the continuum with the same level of commitment we give to prevention, intervention, and treatment. If we don't invest in recovery supports, we won't solve the opioid crisis or the larger addiction crisis in America.

Increase prenatal screening programs to promote early identification of at-risk families and referral treatment and recovery programs.

Prenatal screening programs that remove stigma from substance abuse and provide access to a substance-abuse counselor as part of the routine pre-natal care package, one-on-one education, and support and resources tailored to fit each patient's individual needs have been shown to be effective in improving health outcomes for participants.[14] Parental screening models should

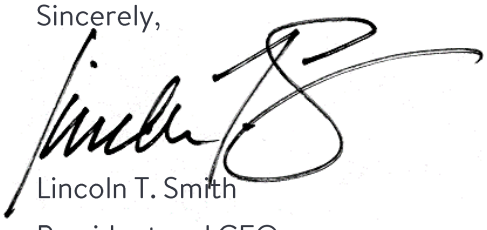
continue to be explored and implemented.

Support school-based education programs to prevent generational cycles of substance abuse.

In Indiana, the nonprofit organization Overdose Lifeline, Inc. created the "This is (Not) About Drugs" educational program in 2014 and has since reached more than 24,000 students in the state of Indiana and communities in California, Georgia, Illinois, Kentucky, Maryland, Mississippi, Michigan, Nevada, Ohio, Pennsylvania, Tennessee, Virginia, and Wisconsin. The program is designed for students in grades 6-12 and helps to raise awareness about the risks of misusing prescription opioids. [15]

There are clearly many policy options open for Medicare and Medicaid to use purchasing power to create new and important incentives to significantly improve upstream and downstream interventions that can be effective in reducing the current burden of the opioid crisis on the U.S. economy. If we stand still, Altarum's analysis suggests that the economic loss to the economy will be $500 billion over the next three years. But beyond this economic burden is the significant human suffering and the impact on families and communities across our great country. We hope that you will consider some of these suggestions as you continue to reflect on what Congress can do to provide solutions to the crisis.

Sincerely,



Lincoln T. Smith
President and CEO

[14] Taillac, Cosette, et al. "Early start: an integrated model of substance abuse intervention for pregnant women." The Permanente Journal 11.3 (2007): 5.

[15] Overdose Lifeline Inc. This is (Not) About Drugs Prescription Pain Medicine (Opioids) and Heroin Prevention Program. Access from: https://www.overdose-lifeline.org/uploads/3/1/1/2/31120819/odl-tinad-flyer-2018.pdf 14 February 2018).