February 8, 2018

The Honorable Orrin G. Hatch
U.S. Senate
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, D.C. 20510

Submitted electronically via opioids@finance.senate.gov

Dear Chairman Hatch and Ranking Member Wyden:

Health IT Now (HITN) appreciates the opportunity to comment on ways to address the opioid epidemic. HITN is a diverse coalition of health care providers, patient advocates, consumers, employers, and payers who support the adoption and use of health IT to improve health outcomes and lower costs.

We applaud the Committee's work on this issue. Addressing it will save lives and, hopefully, billions of dollars in avoidable ER and hospital costs in Medicare and Medicaid.

3. *How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to endure beneficiaries receive evidenced-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?*

HITN agrees that there are many barriers to beneficiaries receiving evidenced-based prevention, screening, assessment, and treatment for OUD and other SUDs. Two of those barriers are the stigma that is attached to treatment and the shortage of medical professionals to provide treatment.

Technology can help bridge the gap of distance and stigma by allowing beneficiaries to receive care when and where they need it. Unfortunately, outdated laws and regulations prevent healthcare providers from using technology to provide care to most beneficiaries. HITN believes that Congress should remove barriers to coverage and reimbursement for telehealth in the Medicare program. It is important this is done in a way that does not incent inappropriate utilization, while allowing for reimbursement of appropriate services regardless of how they are delivered.

According to the Substance Abuse and Mental Health Services Administration (SAMSHA), more than half of U.S. counties lack any practicing behavioral health workers and 77 percent of counties report unmet behavioral health needs. Ancillary care providers can help support medical professionals in ensuring beneficiaries receive evidenced-based prevention, screening, assessment, and treatment; however, many ancillary care provider services are not reimbursed by Medicare. For example, Medicare does not reimburse for peer recovery coaches, which have been shown to improve relationships with treatment providers, increase treatment retention, increase beneficiary satisfaction with the overall treatment experience, improve access to social supports and provide greater housing stability.[1]

HITN believes peer recovery coaches should be integrated into care teams and reimbursed by Medicare. Medicaid already reimburses for such services. At least 36 states allow providers to bill Medicaid for

[1] https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf

mental health peer support services.[2] Medicare should align with other payers in recognizing the importance of these services and providers.

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

Technology and standards that are currently available in doctors' offices and at pharmacy counters, have the ability to inform clinicians about whether to prescribe and dispense an opioid to a patient. Prescription drug monitoring programs (PDMPs) are important sources of data for providers and pharmacists alike, however, PDMPs could be more impactful in combatting the opioid crisis if challenges with the databases are addressed. For example, PDMP data is not real time, often is not in a provider's work flow, and is interoperable to the extent differing or conflicting state and EHR level variances can be addressed. As a result, they lack power in helping providers assess whether a patient is at risk

Interoperability: PDMPs are profoundly different across states, in how they interact with other PDMPs, and in how they are integrated with provider EHRs and pharmacy management systems. These differences present many challenges, and limit provider access to data at the point of care. Improving interoperability of PDMP data will allow providers the ability to check patient prescription histories, alert providers to individuals with patterns indicative of misuse, and prevent patient doctor shopping regardless of geography or technology system.

Real-time: PDMP data currently run on batched information that is collected, refined, uploaded and checked often only once per day or week. This data latency means information is only utilized retroactively to track dispensing data for patients and does little to stop same day forum shoppers. If improvements to the current system would allow an alert to prescribers and pharmacists when patient safety issues are identified. For example, in instances where a patient's prescription history suggests they may be at risk for abuse, the system could notify the pharmacist who could then take additional steps before dispensing, including consulting the state's PDMP, talking with the prescriber and counseling the patient.

Within workflow: Under the current system, the burden is on prescribers and pharmacists to leave their workstations and check a PDMP website. In order to check a state's PDMP, most clinicians and pharmacists are required to log in to a system separate from their normal medical record software (EHR, prescription dispensing system, etc.), query the site, analyze the report results, and then return to their original workflow. Unsurprisingly, research indicates that prescribers and pharmacists do not always, and often infrequently consult PDMPs. Delivering alerts in provider work flow through the very same system that pharmacists use as part of their dispensing process and prescribers use to write e-prescriptions would save considerable time, and most importantly, would increase the likelihood that these healthcare professionals consult their PDMPs.

To address the challenges seen in the current system, HITN recommends standardizing the information across all programs in this area with a data facilitator or aggregator, similar to the Medicare Part D TrOOP facilitator. The Part D system aggregates (in real time) cost information to determine where a beneficiary is in relation to the catastrophic limit. Utilizing the HIPAA and Part D recognized National Council for Prescription Drug Programs (NCPDP) standards – Telecommunication and SCRIPT—information transmitted in real-time through a provider's e-prescribing system and a pharmacy's prescription dispensing system can be standardized, aggregated and provided to a facilitator who could then provide information to clinicians and state-based PDMPs. These secure, real-time, HIPPA compliant standards would be used to populate a facilitator or data aggregator with standard patient prescription information. That data would then be used in conjunction with an algorithm to alert the prescriber or dispenser if a patient presents a risk – anything from a possible drug interaction to an individual who may

[2] http://www.ncsl.org/documents/health/lb_2410.pdf

be doctor shopping. In addition, by utilizing a facilitator to inform state databases, the PDMP information would be greatly enhanced and complete, accurate and real-time. Congress should require a national facilitator to be used in Medicare, similar to the TrOOP facilitator, in order to assist providers in treating patients and to facilitate these standards-based information flows. Certification criteria for EHRs should be modified to require clinical decision support for prescribers.

In order for these policies to be the most effective, however, all relevant information needs to be available, including information on previous treatment for SUD. To this end, HITN recommends amending 42 CFR Part 2 to make the information available to clinicians, for the good of patient care, in accordance with HIPPA, and without specific patient consent.

A model for this program and facilitator has been developed and published by NCPDP in the attached white paper entitled, *NCPDP's Recommendations for an Integrated, Interoperable Solution to Ensure Patient Safe Use of Controlled Substances*. Implementation of these recommendations will result in enhancing the information PDMPs already collect while reducing the burden on providers and pharmacists and ultimately getting necessary data to those prescribers and dispensers who need it to ensure the best patient care.

Providing accurate, real time and actionable information to prescribers and pharmacists at the point of care will help reduce or stop inappropriate prescriptions. This, in turn, will help reduce ER visits and hospitalizations paid by Medicare and Medicaid. We believe, net of costs, this approach will save hundreds of millions if not billions or dollars.

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?*

Given the severity of the crisis, there is an urgent need to link individuals diagnosed with OUD to effective care. In this respect, we see Artificial Intelligence and advanced analytic technologies as important instruments to support physicians and providers and can help organizations unlock and integrate the full breadth of information from multiple systems and care providers, automate care management workflows, and scale to meet the demands of growing populations under management. In helping prescribers and physicians treating people with OUD, analytic and cognitive tools can empower care teams to individualize care plans and recommend the optimal combination of structured programs, best practices and personalized insights, all leading to better management of overall health across the population.

We appreciate the Senate Finance Committee's commitment to addressing the opioid epidemic. We look forward to continuing to work together.

Sincerely,

Joel C. White
Executive Director