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February 16, 2018

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

The Honorable Ron Wyden
Ranking Member
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

Thank you for the opportunity to respond to your request for feedback on ways to address the opioid epidemic. This is a high priority on which we at the National Committee for Quality Assurance (NCQA) are diligently working.

We recently developed new HEDIS®[1] measures that track prescriptions for high dosages and multiple prescribers to help health plans track and address these indicators of potential abuse, overdose and death. They are:

- *Use of Opioids at High Dosage.* This measure assesses the rate of health plan members 18 years and older who receive long-term opioids at high dosage (average morphine equivalent dose >120mg) for 90 consecutive days or longer.
- *Use of Opioids from Multiple Providers.* This measure assesses the rate of health plan members 18 years and older who receive opioids from 4 or more prescribers and 4 or more pharmacies.

The Centers for Medicare and Medicaid Services (CMS) could incorporate these measures into the Medicare Advantage Star Ratings System and other value-based payment programs to emphasize their importance and encourage action on them with powerful financial incentives.

We also offer the following responses on specific questions in your February 2, 2018 request for feedback.

Payment incentives for evidence-based pain care. The CDC *Guideline for Prescribing Opioid for Chronic Pain* made recommendations for pain management and the Institute of Medicine's *Alleviating Pain in America* (2011) summarized evidence-based pain care. NCQA supports Medicare and Medicaid payment to incentivize evidence-based treatment for chronic pain.

NCQA supports recommendations on evidence-based non-pharmacotherapy (e.g., cognitive behavioral therapy, alternative medicine, exercise) and nonopioid pharmacotherapy.

NCQA supports, and is developing pain management measures that align with evidence-based treatment. These include:

- Use of nonchronological and nonopioid therapy as first-line treatment for chronic, noncancer pain.

[1] HEDIS – the Healthcare Effectiveness and Data Information Set, is a registered trademark of NCQA.

- Patient-reported outcome measures (PROM) on pain-related functioning. PROMs can help engage patients in their care and self-management and inform shared decision making for pain care.
- Evaluation for appropriateness of opioid therapy, including benefit and harm assessment, ongoing pain and opioid therapy monitoring and appropriate tapering or cessation of opioid therapy, if clinically applicable.

Medicare and Medicaid should consider these measures in value-based payment models for pain care.

NCQA also supports Medicare and Medicaid incentive payments for pain clinics and programs that use multi-model, evidence-based treatment for pain. Few pain clinics in the U.S. provide comprehensive, multi-disciplinary pain care that includes pharmacists, nurses, social workers, physicians, anesthesiologists, addiction specialists and recreation therapists.

We support use of quality measurement in evaluation of and incentive payment for such programs.

Barriers to pain care. Barriers to use of non-pharmacotherapy for chronic pain include a shortage of pain care providers, lack of payment for evidence-based treatments by health plans and a dearth of claim codes for evidence-based psychotherapy for pain. Provider education on appropriate pain management, implementation of clinical-decision support for appropriate pain care in EHRs, payment for evidence-based pain care and creation of claim codes for evidence-based care would help address these barriers.

Payment incentives for evidence-based treatment and outcomes for addiction. We support Medicare and Medicaid payments to providers for using evidence-based treatment for substance use disorder (SUD) through value-based payment models.

NCQA also supports the use of quality measures on addiction care in value-based payment arrangements and national quality reporting programs such as Medicare Star Ratings and the Medicaid Core Set.

NCQA has been developing and implementing SUD measures, and supports Medicare and Medicaid use of quality measures in quality payment and provider recognition programs to improve addiction care. NCQA's SUD measurement framework includes:

- *Unhealthy Alcohol Use Screening and Follow-Up for Adults.* Unhealthy alcohol use is a leading cause of preventable death in the U.S. Reporting the measure encourages the use of standardized screening tools and evidence-based intervention, such as brief counseling and other treatment.
- *Use of Medication-Assisted Treatment (MAT) for opioid use disorder (OUD).* Although supported by evidence, MAT tends to be under prescribed. The measure provides an opportunity to track the use of MAT for patients with OUD.
- *Screening and treatment of co-morbid mental health and infectious diseases (viral hepatitis, HIV, AIDS).* The SUD population has a higher prevalence of these co-morbid conditions. The measures encourage care coordination across addiction, mental health and primary care to address this population's complex needs.

- *Patient-reported outcome measures on recovery, functioning, employment and housing status.* SUD treatment should help patients function in society. Prioritizing outcomes encourages treatment that addresses the whole person.

The addiction population has complex medical, behavioral and social service needs. NCQA encourages incentives for health care providers and systems that provide high-quality addiction care and wraparound services (e.g., connection with community services on housing, employment support). NCQA is exploring provider evaluation programs for addiction care:

- NCQA's Patient-Centered Medical Home (PCMH) Behavioral Health Integration Distinction, which recognizes primary care practices that address patients' behavioral health needs, including screening, brief intervention and prescribers who can prescribe MAT.
- Addiction Care Provider Recognition. Evaluation criteria include use of evidence-based treatment, patient engagement, timely access to care, care planning and connecting patients with community services. The program encourages transparency and accountability for addiction care quality.

Improve information sharing for SUD. Data sharing about OUD or other SUDs is challenging. Health care professionals have different interpretations of the 42 CFR part 2 Confidentiality of Substance Use Disorder Patient Records regulations. Forming provider networks across the continuum of addiction care (outpatient, residential, inpatient care settings) may help alleviate barriers imposed by the regulations. Linking the Prescription Drug Monitoring Program with EHRs also will help providers make informed opioid prescribing decisions.

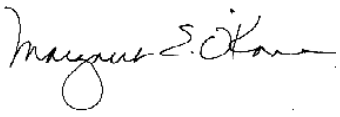
Best practices.

- *Case management* for the addiction population: Medicaid plans in Virginia are using this. This population has complex needs and can benefit from case management services offered through health plans and provider programs. NCQA supports Medicare and Medicaid payment for case management services for the SUD population. NCQA has Complex Case Management requirements for Health Plan Accreditation and PCMH recognition.

Telehealth for addiction. NCQA supports Medicare and Medicaid payment for telehealth services for addiction, which has shown to be as effective as in-person care in reducing substance consumption and improving patient functioning. NCQA allows telehealth services in selected HEDIS quality measures for addiction, mental health and physical health.

Thank you again for the opportunity to share our thoughts on this critical issue. If you have questions, please contact Paul Cotton, Director of Federal Affairs, at (202) 955-5162 or cotton@ncqa.org.

Sincerely,



Margaret O'Kane,
President