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February 21, 2018

Senator Orrin Hatch
Senator Ron Wyden
Committee on Finance
Washington, DC 20510

Dear Senator Hatch and Senator Wyden:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to submit comments on ways to address the opioid epidemic, a crisis that touches every state in the nation. As the healthcare partner to one in three Americans, Blue Cross Blue Shield (BCBS) companies stand committed to our members, our communities and to fighting America's opioid crisis.

BCBSA is the national association that represents the 36 independent, community-based and locally operated Blue Cross and Blue Shield Plans (Plans). Plans participate in all federal insurance programs, including the Federal Employees Health Benefit Program, Medicare Advantage, Part D, CHIP and Medicaid Managed Care programs. BCBS Plans also serve individuals who have purchased coverage in Affordable Care Act (ACA) marketplaces and employers in the small and large group markets.

The nation's opioid epidemic reflects a complex set of circumstances and is one of the most pressing public health issues facing our nation today. According to the most recent statistics from the Centers for Disease Control and Prevention (CDC), opioids (including prescription opioids and heroin) kill more than 33,000 people annually, which is more than any year on record and more than at the peak of the human immunodeficiency virus (HIV) epidemic[1]. One in three Medicare Part D beneficiaries received a prescription opioid in 2016, and almost 90,000 beneficiaries were at serious risk for abuse that year[2]. Medicaid covers nearly 4 in 10 non-elderly adults with opioid addiction[3]. Our Health of America report on Opioid Prescribing published last year reveals that the number of BCBS members diagnosed with an opioid use disorder spiked 493 percent between 2010 and 2016.

[1] Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep. ePub: 16 December 2016.
[2] https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf
[3] https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/

In response to the opioid epidemic, BCBSA launched an executive-level workgroup in 2016 tasked with developing system-wide best practices. Since the beginning of last year, Plans put into action a four-part plan to address opioid use and substance use disorder:

- To raise the public's awareness and to educate them on opioid risks.
- To develop actionable policies and practices that Plans can implement to promote safe prescribing of opioids, and ensure appropriate access to evidence-based treatment for pain and for opioid use disorder.
- To support the enactment of well-informed public policy to prevent opioid misuse, abuse, fraud and diversion.
- To invest in research by convening scientists, academic researchers and clinical experts to develop and implement protocols to successfully reduce rates of relapse.

Additionally, Plans are committed to leveraging the Blue system's data capabilities to enhance understanding of opioid use disorder prevalence and treatment.

BCBS companies have been actively engaged in confronting the crisis, but there are elements to opioid use disorder (OUD) and substance use disorder (SUD) treatment that are outside of the influence of private payers. **We believe that Congress should frame any actions to address the epidemic around three overarching strategies and related recommendations to holistically tackle challenges related to OUD and SUD:**

Ensuring patients receive the right care in the right setting

- Congress should fund a national education campaign to educate physicians and dentists on appropriate prescribing, including a consumer-focused segment targeted to discrete populations such as young adults, the disabled and those with Medicare and Medicaid coverage.
- Congress should support expansion of Project ECHO (a successful program that helps enable peer-to-peer training of providers for treating patients with substance use disorder) to more states, helping bolster the network of trained providers.
- HHS should allow health plans insuring Medicaid and Medicare beneficiaries to limit the first fill of short-acting opioids to seven days, consistent with the CDC Guideline for opioid dose and duration limits, with appropriate exceptions defined by HHS (e.g., for cancer treatment).
- Congress should amend 42 CFR Part 2 to align with HIPAA to facilitate better communication among providers relative to opioid use.

Providing states with the resources to effectively address the epidemic

- Congress should fund additional grants to states to enhance Prescription Drug Management Programs (PDMP) that incentivize states to require physician use of PDMPs as well as remove barriers to health plans' ability to access data.

- Congress should provide additional funding to states most affected by the epidemic to address the shortage of behavioral health care professionals needed to treat substance use disorders, including creating incentives to encourage practitioners to become certified to administer medication assisted treatment (MAT).
- States need enhanced Medicaid reimbursement rates for practitioners authorized to administer medication assisted treatment (MAT). In addition, to improve access to MAT, it should be mandatory that all FDA-approved MAT therapies are covered by all state Medicaid programs.

Addressing fraud and abuse

- Congress should require federal, state and local governments to subject all addiction treatment facilities (including sober/recovery homes) and programs to the same mandatory and rigorous licensing and oversight as other health care facilities.
- Congress should restrict third party payment of premiums in any programs funded by the government by facilities and marketers that have a financial interest in placing and receiving patients with substance use disorder.
- Finalize proposals that expand the use of "lock-in" initiatives for at-risk beneficiaries in all programs funded by the government, as applicable (e.g., Medicare, Medicaid, VA, FEHBP, and the individual market).
- To better track prescribing of controlled substances, Congress should provide states incentives for adopting policies requiring e-prescribing of controlled substances by health systems and prescribers.

We have outlined our detailed recommendations on the questions for which you sought feedback in the following text. Many of the featured recommendations are general in scope, and in many cases program-agnostic. Therefore, further evaluation and statutory approval may be needed before CMS can take these recommendations and implement them in the Medicare and/or Medicaid programs.

We share your commitment to supporting communities and helping individuals suffering from opioid use disorder get the care they need. We appreciate your consideration of our comments on potential recommendations to address the opioid epidemic and substance use disorder and look forward to continuing to working with you to address the opioid crisis.

Sincerely,

Justine Handelman

Senior Vice President, Office of Policy and Representation

BCBSA Detailed Comments on Recommendations to Address Opioid Use Disorder (OUD) and Substance Use Disorder (SUD)

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?**

A key contributor to the opioid epidemic has been excess prescribing of opioids for common pain complaints and for postsurgical pain. For some conditions, behavioral programs, acupuncture, chiropractic, physical therapy, and FDA-approved multimodal pain strategies have been proven to reduce the use of opioids while providing effective pain management—but current CMS reimbursement policies create barriers to the adoption of these strategies.

Issue: The current CMS payment policy for "supplies" related to surgical procedures creates unintended incentives for those that prescribe opioid medications to patients for postsurgical pain instead of administering non-opioid pain medications. As a result of this policy, hospitals receive the same fixed fee from Medicare whether the surgeon administers a non-opioid medication or not.

Any costs the hospital incurs for creating and administering a multimodal pain management strategy essentially get deducted from its fixed fee payment. Thus, purchasing and administering a non-opioid medication in the operating room increases the hospital's expenses without a corresponding increase in reimbursement payment.

Recommendation: CMS should review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain.

Issue: A number of states collect important information about substance use disorder, behavioral health, nonmedical opioid use, and overdose. However, there is no coordinated forum that exists to share lessons learned about what is working in fighting the epidemic and to facilitate diffusion of best practices.

Recommendation: Require HHS to identify and share model strategies to support state and local implementation of best practices for prevention, treatment, and ongoing maintenance of the disease.

Issue: While a variety of providers may administer substance use disorder screening and treatment services, reimbursement rates may not be adequate for primary care providers that provide such services to their patients. Particularly in rural areas, primary care providers are very likely to provide MAT treatment for their patients as other providers are unavailable. These primary care providers devote more time and resources for these patients with complex substance use or opioid use conditions than their usual patients.

The lack of adequate reimbursement rates exacerbates an existing provider shortage in treating substance use disorders.

Recommendation: Reimbursement rates to primary care providers for screening and treatment of substance use disorders should be increased to incentivize more providers to offer these services, especially in rural areas.

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?**

Used appropriately, prescription opioids can provide relief to patients. Unfortunately, these therapies are too often being prescribed in quantities that are excessive and for conditions not supported by clinical evidence. Non-drug therapies, including chiropractic care, acupuncture, massage therapy, and physical and occupational therapy, as well as non-opioid pharmacological therapies may be sufficient to treat and/or manage pain for some patients. However, prescriber education on appropriate opioid prescribing and subsequent education on effective non-opioid therapies currently is lacking and will be necessary for any sustainable cultural shift regarding non-pharmaceutical therapies for chronic pain (see our recommendations under Question 5 for additional details).

A growing number of states are providing coverage for non-pharmacological alternatives to opioids, such as chiropractic care. To expand the use of non-opioid therapies, state Medicaid programs need the flexibility to implement state-specific interventions. CMS should allow states the flexibility to implement new programs, beyond 1115 waivers and State Plan Amendments.

Issue: Medicaid beneficiaries are more likely to have multiple chronic conditions and are prescribed opioids at a disproportionately higher rate than non-Medicaid populations. Opioids are clinically indicated and appropriate for a range of pain types, however the evidence base around alternative, non-pharmacological treatments (e.g., acupuncture, chiropractic treatment, physical therapy, cognitive behavioral therapy) for long-term, non-cancer pain is limited. While the majority of state Medicaid programs provide coverage for alternative treatments in lieu of opioids, less than half of them encourage or require their use[4]. Furthermore, states that provide these treatments commonly carve out the benefit from Medicaid managed care contracts, leaving Medicaid managed care organizations to cover services without reimbursement.

Recommendation: State Medicaid agencies should use a number of policy options to provide coverage for or require the use of alternative treatments to opioids, including:

[4] https://nashp.org/wp-content/uploads/2016/09/Pain-Brief.pdf

- Allowing for additional flexibility beyond existing Medicaid authorities to cover alternative treatment services (without the need to go through the cost, development and management of an 1115 waiver or State Plan Amendment);
- Integrating alternative pain management treatment services into Medicaid managed care contracts;
- Ensuring adequate reimbursement rates for providers of alternative pain treatment services to encourage provider participation in Medicaid; and
- Using waiver demonstration programs to cultivate a broader evidence base for the use of alternative, non-pharmacological treatments by evaluating whether such therapies are effective pain management tools for the use of chronic or long-term, non-cancer pain.

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 or other SUDs to improve patient outcomes?

Multiple studies have shown that individuals receiving Medication-assisted treatment (MAT) during and after incarceration have lower mortality risk, remain in treatment longer, have fewer positive drug screens, and have lower rates of recidivism than other individuals with OUDs that do not receive MAT.

Patients suffering from SUD or OUD need an array of services to increase their chance of recovery. By removing barriers to evidence-based care, CMS can ensure Medicare and Medicaid patients are receiving appropriate treatment for SUD.

Issue: Because there is a workforce shortage of providers in behavioral healthcare, there are too few qualified practitioners certified to administer MAT. Federal law requires physicians to complete training and apply for a waiver to prescribe buprenorphine (part of MAT), but even after doing so, physicians are limited to treating up to 30 patients in the first year, after which physicians may apply to treat up to 100 patients.

Recently, physicians who have prescribed buprenorphine to 100 patients for at least one year have been able to apply to increase their patient limits to 275. A SAMHSA database of physicians by state who are eligible to provide buprenorphine treatment for opioid dependency[5] illustrates the need for more MAT-certified providers. For example, there are only 3 physicians in Nebraska who are certified to treat up to 30 patients, and none who are certified to treat up to 100 patients. The numbers are the same for North Dakota, and are even lower for South Dakota, which has just a single physician certified to treat up to 30 patients.

[5] Number of certified physicians by state who are eligible to provide buprenorphine treatment for opioid dependency, 2018 https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians

Recommendation #1: Create incentives to encourage additional practitioners (e.g., nurse practitioners, clinical pharmacy practitioners, and physician assistants) to become certified to administer medication assisted treatment (MAT).

Recommendation #2: Provide enhanced Medicaid reimbursement rates for practitioners authorized to administer medication assisted treatment (MAT) and require all FDA-approved MAT therapies to be covered by all state Medicaid programs.

Issue: Some unscrupulous drug and alcohol treatment centers pay individuals or outside companies to "recruit" drug addicts into their treatment program with cash and material incentives (e.g., prepaid debit cards). If a patient already has insurance, the treatment centers collect fees from insurance companies just for the drug testing stage, without necessarily following up and providing the full range of treatment and care needed. If the patient is uninsured, some patient brokers will enroll them in an insurance plan and pay for their first month of coverage.

Recommendation: Restrict third party payment of premiums in programs funded by the government by facilities and marketers that have a financial interest in placing and receiving patients with substance use disorder. Addressing fraud and abuse is critical – money spent on dealing with unethical/illegal activities is money that could be spent towards treatment.

Issue: Every state Medicaid program provides coverage for the following prescription medications used to treat opioid use disorder: buprenorphine, buprenorphine-naloxone combination, and naltrexone. As noted previously, in order to prescribe and/or dispense buprenorphine, physicians must complete a waiver application and training in order to become DATA-waived. Despite 2016 efforts to expand eligible providers and increase patient limits, there continue to be significant gaps in provider capacity across all states, especially in rural areas. Furthermore, the MAT provider gap continues to grow as more newly eligible Medicaid beneficiaries with unmet behavioral and substance use disorder needs are referred for MAT treatment.

Recommendation: Although all state Medicaid programs provide coverage for buprenorphine and naltrexone, methadone is not covered in every state. In order to provide more robust access to evidence-based, clinically appropriate treatment options, CMS should require that all FDA-approved MAT therapies be covered by all state Medicaid programs. For the purposes of expanding access to providers certified to administer MAT services, enhanced Medicaid reimbursement rates may be used to encourage eligible providers to become DATA-waived. Additionally, states may consider expediting provider credentialing processes for MAT providers to enroll them in the Medicaid program as quickly as possible.

Issue: The Institutions for Mental Disease (IMD) exclusion does not allow states to use federal Medicaid dollars for care provided to patients aged 21-64 in mental health and substance use disorder residential treatment facilities larger than 16 beds. All substance use disorder

treatment facilities with more than 16 beds are considered IMDs. Thus, certain substance use disorder treatments that require long stays in an inpatient facility, such as detoxification and rehabilitation services, are not covered under the IMD exclusion.

Recommendation: Though recent policy changes give more flexibility to MCOs in regards to IMDs and states can make changes using waivers, policymakers should formally eliminate the IMD exclusion. In the absence of such a change, states should leverage the administration's flexibility to use federal Medicaid funds to pay for IMD substance use treatment services through Section 1115 waivers. As of February 1, 2018, eight states (California, Kentucky, Maryland, Massachusetts, New Jersey, Utah, Virginia, and West Virginia) have waiver authority to use federal Medicaid funds to pay for IMD substance use treatment services. CMS should also continue to expedite approval of Section 1115 waivers that address the IMD exclusion. Currently, there are waiver requests from nine states (Arizona, Illinois, Indiana, Kansas, Michigan, North Carolina, New Mexico, and Wisconsin) and a request to expand existing waiver authority in one state (Massachusetts) that are pending approval.

Issue: Screening, Brief Intervention, and Referral to Treatment (SBIRT) services are an evidence-based practice intended to identify, reduce, and prevent substance use disorders, including opioid use disorder. They are simple tools used by a wide range of primary care providers to screen and assist individuals who may not seek treatment for an existing substance use disorder. In the Medicaid program, states may choose to provide coverage for SBIRT services for adults as a preventive service or a brief intervention. However, coverage of SBIRT services is not required by the Medicaid program.

Recommendation: Encourage state Medicaid agencies to consider including SBIRT services within their state plans to provide coverage and reimbursement for such services. In states where SBIRT services are currently covered, value-based payment incentives that provide enhanced reimbursement to primary care providers that use SBIRT services may encourage broader provider adoption and use of this simple tool. Additionally, SBIRT services may be provided through telehealth platforms if permitted by the state. States should also consider enhancing the reimbursement rate for SBIRT services provided via telehealth to promote use of the tool by primary care providers in rural areas, thereby increasing access.

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?**

We are pleased to partner with CMS in its many efforts to continue to decrease inappropriate dispensing of opioids as well as change other program elements that have contributed to the ability of some Medicare beneficiaries who inappropriately access opioids as an unintended consequence of some existing enrollment and "transition" policies.

BCBSA commends CMS for putting in place requirements to monitor the use of opioids. There are several new proposals in play today, which if finalized will help decrease inappropriate access and overutilization of opioids in Medicare Part D:

1) Proposals in the CY 2019 Call Letter addressing the current Overutilization Monitoring System (OMS) in Part D.
2) Proposals in the pending Medicare Advantage and Part D rule that implement CARA, legislation that gave Part D sponsors new authority to address opioid over utilization and allow a Part D sponsor to limit an at-risk beneficiary to selected pharmacies and prescribers when there has been documentation of "doctor shopping " with an patient. Such a "lock-in" provision is in place in many of our commercial lines of business and also in Medicaid.
3) New restrictions on how many times a "dual eligible" can change their Medicare Advantage or Part D plan.
4) Changes to the current transition policy where a new MA or Part D member was given a 90-day supply of their current medication.
5) Proposals to implement a supply limit for initial fills of prescription opioids (e.g., 7 days) for the treatment of acute pain with or without a daily dose maximum (e.g., 50 MME).

All of the above taken together will help stem the overutilization and inappropriate dispensing to beneficiaries in Medicare Advantage and Part D. BCBSA is pleased to support all of these proposals.

Issue: Utilization management is an effective tool in ensuring patient safety and helping minimize the number of inappropriate opioids prescribed.

Recommendation: CMS should finalize its proposed strategies to more effectively address this issue for patients in Part D, which includes requirements of sponsors to: implement safety edits at the point-of-sale for opioid prescriptions at 90 morphine milligram equivalent (MME), with a seven-day supply allowance; implement a supply limit for initial fills of prescription opioids (e.g., seven days) for the treatment of acute pain with or without a daily dose maximum (e.g., 50 MME); and implement point-of-sale safety edits based on duplicative therapy of multiple long-acting opioids, and to request feedback on concurrent prescription opioid and benzodiazepine soft edits.

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

In the early 1990s, the American Pain Society opined that there was a national epidemic of untreated pain in our nation's hospitals and announced that pain should be classified as the "fifth vital sign". The origins of the current opioid crisis lie in part in the embrace of this assessment by the medical community, with opioid prescribing as an accepted solution.

Countering this now-accepted practice will require concerted education, not just of providers, but of individuals, who have come to expect a prescription for pain medication as a way to address their pain, and who may be less interested or willing to take the time and effort to address their pain with non-drug alternatives such as physical therapy or chiropractic care. In a recent study, providers reported patient skepticism about the effectiveness of non-pharmacological treatment options as a key barrier to managing chronic pain without opioids.[6]

Issue: Provider and patient education about the risks of prescription opioids and alternatives for pain management is needed, particularly around helping individuals understand the benefits of non-opioid treatments for managing acute or chronic pain.

Recommendation: Launch a national educational campaign to educate physicians and dentists on appropriate prescribing, which should include both information as well as direct skill development in assessment and treatment of opioid-use disorders. In parallel, a consumer-focused campaign should be targeted to discrete populations such as young adults, the disabled, and those with Medicare and Medicaid coverage to educate them on the dangers of opioids and appropriate treatment options.

Issue: States need federal assistance to develop and expand the existing behavioral health care workforce so that treatment is available to all individuals with opioid-use disorders in a timely manner.

Recommendation: Provide additional funding to states most affected by the epidemic to address the shortage of behavioral health care and support professionals needed to treat substance use disorders.

Issue: Rural and underserved areas often have limited resources and capacity to provide their local health care workforce with the tools needed to manage patients with complex conditions such as substance use disorder or opioid use disorder.

Recommendation: Support expansion of Project ECHO (Extension for Community Healthcare Outcomes - a successful program that helps enable peer-to-peer training of providers for treating patients with substance use disorder) to more states. Project ECHO connects urban medical center disease experts with rural general practitioners and community health representatives over a telehealth network. This enables them to effectively treat patients on site who would otherwise have to travel to urban healthcare facilities for specialty treatment[7].

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[6] "Barriers and facilitators to use of non-pharmacological treatments in chronic pain," March 2017 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5359906/

[7] https://healthit.ahrq.gov/ahrq-funded-projects/project-echo-extension-community-healthcare-outcomes

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

Prescription Drug Monitoring Programs (PDMPs) provide information to health care providers so they can better understand what is being prescribed and intervene before a prescription drug abuse disorder becomes chronic. Currently, PDMPs exist in 49 states, but they are underutilized by providers. Studies suggest that physicians access PDMP data less than 25 percent of time prior to prescribing an opioid and one national study reports that 28 percent of primary care physicians were not aware of their state's PDMP.

In addition, only one state (Michigan - and only in the context of fraud, waste, and abuse investigations) allows private payers access to PDMPs. As a result, most third party payers typically only have access to data on prescriptions for which they've paid; in contrast, PDMP data provides a complete prescription history for a particular patient. Allowing third-party payers access to these data would thus enhance their ability to identify problematic behaviors such overprescribing of opiates by particular providers.

Issue: Prescription Drug Monitoring Programs (PDMPs) are valuable tools that have been shown to assist providers in identifying patterns on overprescribing, misuse, abuse and diversion. Unfortunately, in most states, health plans do not have access to the PDMP.

Recommendation: Congress should support and pass a low allowing health plan access to PDMPs, and CMS should work with states to integrate this access into existing structures. Health plans have a central role to play in assuring healthcare quality and in addressing substance use disorders and the opioid epidemic. Without access to PDMP data, health plans do not have a complete picture of prescribed controlled medications. Access to PDMP data coupled with requiring that prescribers review the PDMP (if one is available) prior to writing opioid scripts would fill in these gaps and promote more effective interactions with physicians to ensure a patient's safety and appropriate treatment.

Issue: Electronic prescribing of controlled substances improves patient safety, increases efficiencies and reduces fraud, waste and abuse. Electronic prescribing of controlled substances is now permitted in all 50 states, but it is not mandatory.

Recommendation: Provide states incentives for adoption of policies requiring e-prescribing of controlled substances. States should encourage prescribers to transmit prescriptions for controlled substances electronically as a way to better track controlled substances. Promoting electronic prescribing (e-prescribing) has been an essential strategy in helping allow doctors, pharmacies and law enforcement to better monitor inappropriate opioid use and reduces drug diversion.

Issue: Current Substance Abuse and Mental Health Services Administration (SAMHSA) regulations restrict integration of behavioral health and physical health records, as well as access to prescribing information, acting as a barrier to coordinated care.

Recommendation: HHS should modify and modernize SAMSHA rules for government programs to allow integration of behavioral health and physical health records, as well as to allow providers and health plans access to prescribing information (e.g., allow for data collection, data sharing, and access to PDMPs with appropriate privacy protections). When these regulations were written, the concern was that the potential release of records could lead to employment discrimination for those undergoing substance abuse treatments. These regulations are much stronger than HIPAA guidelines and keeps information from being shared today. Health plans and providers need appropriate access to relevant patient information and data collection systems to provide coordinated comprehensive care.

Issue: Current misalignment between 42 Code of Federal Regulations ("CFR") Part 2 and HIPAA is creating barriers to effective communication exchange among providers and patients' families to improve care.

Recommendation: Align 42 CFR Part 2 with HIPAA to facilitate better communication among providers to improve patient care relative to opioids. Significant roadblocks remain in sharing information between providers. Two bills could make a difference in removing these obstacles:

- H.R. 3545, the "Overdose Prevention and Patient Safety Act," aligns federal regulations addressing the confidentiality of drug and alcohol treatment and prevention records with HIPAA requirements.
- S. 581 (Jessie's Law) would require HHS to establish standards for hospitals and physicians on displaying the history of opioid addiction in medical records of patients who have provided such information to a provider.

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?**

The opioid epidemic is a complex problem, one that requires all stakeholders to work together. Any efforts to address the opioid epidemic and substance use disorder should support the full continuum of care from outpatient to residential treatment, based on medically appropriate and accepted standards of care. Collaboration among stakeholders could prove particularly fruitful in the area of sharing best practices among and between public and private programs.

Blue Plans have been at the forefront of implementing powerful strategies to combat the opioid epidemic in the commercial and Medicaid markets, including lock-in programs and prescription limits. Plans leverage tools such as prior authorization and required treatment plans to ensure CDC guidelines are followed and to ensure patient safety. Medicare and Medicaid should adopt similar strategies more aggressively to help prevent beneficiaries from developing OUD and SUD.

Issue: Opioids are often used as the first-line or routine therapy for chronic pain.

Recommendation: Medicare and Medicaid should adopt CDC guidelines for opioid dose and duration limits for Medicaid and Medicare with appropriate exceptions defined by HHS (e.g., cancer treatment). Specifically:

- Opioids should not be the first-line or routine therapy for chronic pain as they present serious risks.
- If prescribed an opioid, it should be the lowest possible effective dose for the shortest duration of time.

A number of BCBS companies are working alongside physicians to implement these and other best practice prescribing protocols.

Issue: Of the 98 million Americans who take prescription opioids each year, almost 3 million receive their prescriptions from 5 to as many as 20 different physicians. The practice, often called "doctor shopping," allows opioid-addicted individuals to consume an enormous and dangerous number of pills with the unwitting help of doctors. [8]

Recommendation: The use of "lock-in" initiatives for at-risk beneficiaries should be expanded to all programs funded by the government, as applicable (e.g., Medicare, Medicaid, VA, FEHBP, the individual market).

Under a lock-in program, an enrollee's prescriptions for opioids will only be covered if they are written by a single provider of the patient's choosing. Evaluations of Medicaid lock-in programs generally show they decrease prescribing of opioids as well as other controlled substances, such as benzodiazepines. North Carolina's program for example, reduced controlled substance prescriptions by 17 percent among Medicaid enrollees who had histories of unusually large numbers of prescriptions and prescribers.

Issue: Adult Medicaid enrollees are commonly subject to income and employment changes that may require them to transition in and out of Medicaid eligibility, causing churn. Churn is very disruptive for the medical management of Medicaid beneficiaries and makes it more difficult for Medicaid Managed Care Organizations to meet the needs of their enrollees. If an adult Medicaid beneficiary is receiving treatment for substance use disorder or opioid use disorder and loses Medicaid eligibility, their treatment may be interrupted, risking the health of the individual.

Recommendation: States have the option to provide children with 12 months of continuous coverage through Medicaid and CHIP in order to ensure that children receive appropriate preventive and primary care and uninterrupted treatment for medical conditions. While this

[8] https://www.washingtonpost.com/news/wonk/wp/2017/09/25/how-insurance-companies-can-help-fight-the-opioid-epidemic/?utm_term=.e58b3854cdf4

flexibility is offered for children, 12-month continuous eligibility is not available for adults enrolled in Medicaid. The adoption of 12-month continuous eligibility would allow states to disregard the requirement in federal Medicaid regulations that enrollees report changes in income prior to their regularly scheduled redetermination and would reduce churning. For Medicaid enrollees undergoing substance use disorder and opioid use disorder treatments and services, this would promote adherence to treatments and increase the likelihood of successfully treating and managing their substance use disorder.

Issue: A barrier to ensuring that beneficiaries receive the highest-quality, evidenced- based treatment is the lack of uniform requirements for and oversight of treatment facilities (vary by state). Some inpatient treatment facilities do not have to meet the same rigorous licensing and certification standards as hospitals. Accrediting bodies, licensing entities, and credentialing organizations can help remove organizations that are profiting from the crisis through unethical marketing practices and sub-standard care.

While quality recovery residences operate in accordance with accepted national guidelines, such as the standards developed by the National Alliance for Recovery Residents (NARR) or the charter Oxford Houses must follow, some residences do not meet these or state-established standards.

Recommendation: Require federal, state, and local governments to subject all addiction treatment facilities (including sober/recovery homes) and programs to the same mandatory and rigorous licensing and oversight as other health care facilities.

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?**

New programs are emerging across the country to use peer recovery coaches and other types of community health workers, such as health educators, medical assistants, and community health outreach workers, in a range of settings, including hospitals, to provide immediate and ongoing support and treatment linkages to individuals who have overdosed from opioids, or support individuals newly in recovery. Unfortunately, they exist in far too few communities. The use of these types of care extenders can help address the workforce shortage, but more of them are needed.

Issue: Paraprofessionals and trained peers play a key, but underappreciated role, in helping patients access treatment for and recover from opioid and substance use disorders. An adequate supply of these individuals is needed to ensure access to on-demand treatment. Providers who interact with individuals who have substance use issues also need to be made aware of the community-based resources in their area.

Recommendation: CMS, through its regional offices should identify local specialized paraprofessional and peer support resources and share that information with participating providers – particularly, hospitals, primary care providers, providers who treat substance abuse, and providers who specialize in pain treatment. By creating these linkages, especially in hard-hit areas, CMS can encourage providers who are most likely to come into contact with individuals who have substance use issues, to help those individuals receive the care they need.

Issue: Parents with dependent children who undergo substance use disorder or opioid use disorder treatment are at risk of losing custody of their children due to criminal penalties or because they are unable to bring their children with them to residential treatment facilities. These state laws or facility rules can pose a barrier for Medicaid beneficiaries to access care and treatment for their conditions.

Recommendation: Sobriety Treatment and Recovery Teams (START) are intensive child welfare programs for families with at least one child (under six years of age) who is in the child welfare system and a parent whose substance use disorder is identified as a safety risk factor for the child. These programs pair child protective services workers with a peer support mentor that works with the family using a system-of-care and team decision-making approach. Key goals of START programs are to ensure child safety, achieve child permanency with one or both parents, achieve parental sobriety, and improve collaboration between child welfare and mental health treatment providers. The use of START programs for Medicaid beneficiaries in need of substance use disorder services may facilitate treatment of parents while preventing or mitigating adverse impacts from OUD or SUD on children and families. There is good evidence that this model works, as demonstrated in Kentucky[9]:

- Mothers receiving START services have higher rates of sobriety than mothers who do not participate in START (66 percent vs. 36 percent, respectively).
- Children in families receiving START services are 50 percent less likely to enter foster care or out-of-home placements than those who do not.
- Upon child protective services closing cases, more than 75 percent of children remain with or were reunited with their parent(s).
- The program yields cost savings – for every $1.00 spent on START $2.22 is saved on out-of-home placements.

[9] http://chfs.ky.gov/dcbs/start.htm