Lifespan's Response to Senate Finance Committee Request

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?**

- Remove pain questions from federal patient satisfaction surveys because it promotes narcotic use.
- Pain contracts, prior authorizations, and availability of non-opioid adjuncts can help with monitoring and prevention of OUD and improve pain control.
- Access to pain specialists is limited. Could consider using a model like Project ECHO to support capacity building for pain management and MAT for OUD in primary care settings.
- New reimbursement models are necessary to incentivize programs that create an effective team with the proper time to assess, develop and carry out a treatment plan.

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?**

- Remove prior authorization or increase limits on physical therapy, or even reimbursement for this in acute care setting.
- There is lack of/limited coverage for services like acupuncture, clinical massage therapy, or other alternative therapies. Offering incentive or coverage of these alternative pain control strategies would decrease barriers, as would ensuring adequate coverage of non-opioid topical medications, such as lidocaine patches, diclofenac gel or patches.
- Remove pain questions from federal patient satisfaction surveys because it promotes narcotic use.

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?**

- Removing any prior authorization for MAT.
- Cover costs of naloxone distribution from the emergency department.
- Offer and advertise availability of reimbursement for substance use screening and Brief Negotiated Interviewing done by either work, nursing, mental health workers, physicians, community health workers, or peer recovery coaches with metrics (e.g., preventing overdose deaths, recidivism, and referrals to MATs) for the effectiveness of such programs.
- Supplement buprenorphine training cost, either by paying course fee or reimbursing providers for time at course.
- Support development of ED-specific short training to encourage ED MAT initiation.
- Pay for residents to attend buprenorphine waiver training as part of residency curricula.
- Increase reimbursement for OUD-treatment visits (they are more time and counseling intensive).

- Develop reimbursement incentives for linkage to treatment from the emergency departments to promote linkage to treatment and MAT initiation.

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?**

- CMS has already taking steps to work on this. They have said they would follow CDC prescribing guidelines in the past, and have recently drafted some draft regulations for more stringent limits (comments currently open): https://www.medpagetoday.com/psychiatry/opioids/70905
- Of note, Dr. Elizabeth Samuels did a study this year (attached) that showed that many Medicare formularies (33%) do not set prescription limits on opioids in line with CDC guidelines.

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

- Pay for resources for state health departments to proactively review prescribing data and give more feedback; give state departments of health resources to track.
- Currently, this is done through the PDMP. Should also include co-prescribing of benzodiazepines and opioids, given increased risk of overdose with co-prescribing.
- Pharmaceutical industry did a lot of academic detailing to get people prescribing opioids. Therefore, we will need to do detailing to correct their misinformation and counsel on appropriate prescribing practices, educate providers on non-opioid means of pain control to meet their patients' needs, and how to taper patients, if necessary.

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

- PDMPs need to be national. All PDMPs are currently state based. States using the same vendor can easily access each other records, but this is not true between PDMP vendors.
- Also, the OTP's should be mandated to report suboxone and methadone into the PDMP. That they are exempted is a significant problem.
- Finally, pay for integration of PDMP into EMR's.

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?**

- Consider paying for peer coaches---only if we can document they refer to MAT. (they are currently grant funded or paid for from provider's operating budgets.)
- Rhode Island has been a leader on in this arena, and last year established hospital treatment standards for OUD and after opioid overdose (see RI Levels of Care document). There are only three hospitals

remaining to achieve certification (including the VA). RI has also begun a "Safe Stations" program, where fire departments are a site of addiction treatment linkage. If linked to a hospital system or clinic, could reimburse for a station-based mental health, substance use, or social worker with police and/or fire for treatment linkage.

- Hub and spokes MAT programs, linking patients to community providers (ex. VT, RI)
- Use of Project ECHO to support MAT and OUD treatment in primary care settings.

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?**

- OUD and SUD create chaos not only for patients with OUD and SUD, but also their families. To prevent and mitigate adverse impacts, families may need counseling, additional social supports, assistance with linking their loved one to treatment, and services navigation. These types of wrap around services require federal funding. This may also include social determinants of health, such as transportation and food assistance, educational support for children.

OBSERVATION: BRIEF RESEARCH REPORT

Medicare Formulary Coverage Restrictions for Prescription Opioids, 2006 to 2015

Background: Over the past 2 decades, prescription opioid sales and overdose deaths have quadrupled (1). Risk for unintentional overdose is increased when longer-acting opioids and higher dosages are prescribed (2, 3). Older patients are particularly vulnerable to opioid-related complications and injury (4). Addressing these risks, the 2016 opioid prescribing guidelines from the Centers for Disease Control and Prevention (2) suggest a trial of nonopioid therapies before opioid initiation, use of opioids only when expected benefits outweigh risks, reassessment of risks and benefits when prescribing dosages greater than 50 morphine milligram equivalents (MME) per day, and prescribing no more than 90 MME/d.

Restricting formulary coverage for prescription drugs is 1 strategy to decrease opioid prescribing. A private insurer showed that implementing prior authorization, quantity limits, and provider–patient agreements was associated with a 15% decrease in opioid prescribing (5). The extent to which opioids are covered and/or restricted among formularies serving Medicare beneficiaries is unknown.

Objective: To characterize the extent to which utilization management strategies have been used to restrict access to prescription opioids among Medicare Part D formularies over the past decade.

Methods and Findings: We used the Centers for Medicare & Medicaid Services prescription drug plan formulary files to compare coverage in 2006, 2011, and 2015 for all available doses of commonly used short- and long-acting opioid medications except for methadone, which was excluded. These files include data on all Medicare Advantage and standalone Part D plan formularies that have submitted complete and accurate information to the Centers for Medicare & Medicaid Services. Although lack of formulary coverage may not be intended to restrict opioid prescribing, it creates a financial barrier to prescription opioid access.

We determined the median proportion of drug–dosage combinations that formularies did not cover; covered but did not restrict; and restricted through prior authorization, step therapy, or quantity limits. We also calculated whether prescribed dosages were limited to less than 50 MME/d or 50 to 90 MME/d or whether those greater than 90 MME/d were permitted. We graphed results for hydrocodone–acetaminophen, a commonly prescribed short-acting opioid frequently implicated in overdose-related deaths, to show our findings at the individual drug level.

Data were available for 324, 244, and 389 formularies in 2006, 2011, and 2015, respectively. In 2006 and 2011, more than two thirds of drug–dosage combinations had no opioid prescribing restrictions; in 2015, approximately one third had no restrictions (**Table**). Few formularies required step therapy, but requirements for prior authorization increased over time (from a median of 0% in 2006 and 2011 to 4.4% in 2015). The median proportion of drug–dosage combinations with quantity limits increased from 8.9% in 2006 to 22.2% in 2011 and 71.1% in 2015. Dose restrictions to less than 50 MME/d increased from a median of 2.2% of drug–dose combinations in 2006 to 4.4% in 2011 and 13.3% in 2015.

Formularies increased coverage for hydrocodone–acetaminophen at all dosages between 2006 and 2015 (**Figure**). Although no formularies required prior authorization or step therapy for this drug, the daily dosage was increasingly restricted for the 5 mg/325 mg and 7.5 mg/325 mg formulations, with a greater proportion limiting prescriptions to less than 90 MME/d between 2006 and 2015. Restrictions on MME per day for the 10 mg/325 mg formulation increased slightly from 2011 to 2015, with approximately 80% permitting prescribing greater than 90 MME/d in 2015.

Discussion: Medicare Part D formularies increasingly used quantity limits and, to a lesser extent, prior authorization to restrict daily allowable prescribed dosing of prescription opioids between 2006 and 2015. Despite increased formulary restrictiveness, unrestrictive coverage persisted for many opioids, especially at high doses, including for drugs commonly associated with overdose. Although the overall number of formularies with available data varied across years, changes in how many formularies provided information are unlikely to have affected this general trend.

As shown by formulary coverage of hydrocodone–acetaminophen, formularies tended to be less restrictive at

Table. Median Medicare Part D Formulary Requirements for Prior Authorization, Step Therapy, Quantity Limits, and MME per Day of 45 Opioid Drug–Dose Combinations in 2006, 2011, and 2015*

Formulary Coverage	2006 Formularies (n = 324)	2011 Formularies (n = 244)	2015 Formularies (n = 389)
No coverage	20 (13.3–35.6)	15.6 (4.4–24.4)	17.8 (11.1–33.3)
Coverage with no restrictions	66.7 (51.1–80.0)	66.7 (53.5–77.8)	33.3 (28.9–44.4)
Requires prior authorization	0 (0–4.4)	0 (0–8.9)	4.4 (0–11.1)
Requires step therapy	0 (0–0)	0 (0–0)	0 (0–0)
Imposes any quantity limit	8.9 (0–28.9)	22.2 (8.9–40.6)	71.1 (60.0–84.4)
Imposes a specific quantity limit			
<50 MME/d	2.2 (0–6.7)	4.4 (2.2–6.7)	13.3 (8.9–17.8)
50–90 MME/d	2.2 (0–8.9)	6.7 (4.4–13.3)	24.4 (20.0–33.3)
>90 MME/d	4.4 (0–13.3)	11.1 (2.2–24.4)	31.1 (26.7–37.8)

MME = morphine milligram equivalents.
* Values are percentages, and values in parentheses are interquartile ranges.

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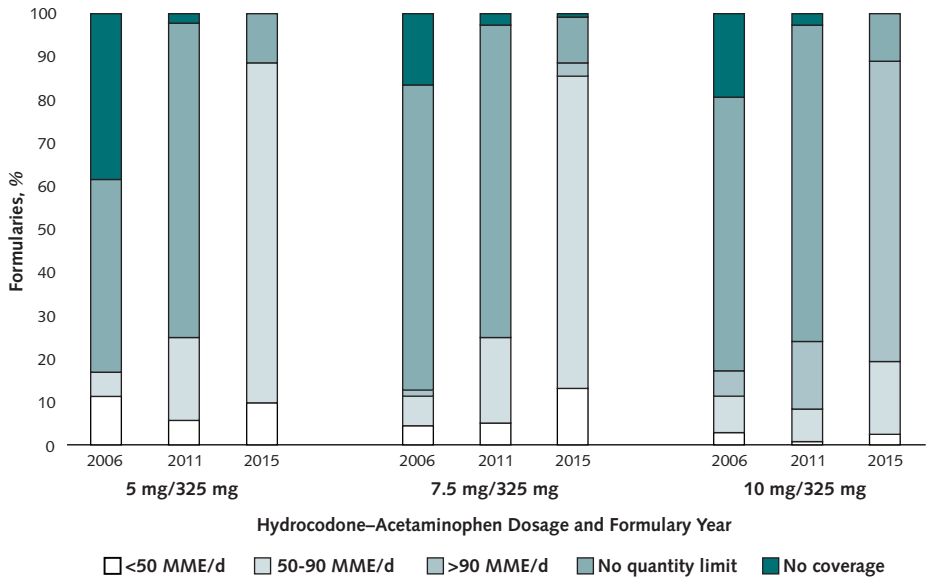
Figure. Medicare formulary daily dosage restrictions of hydrocodone–acetaminophen: 2006, 2011, and 2015.



MME = morphine milligram equivalents.

higher doses, largely because they maintained identical quantity limits regardless of dose. This factor allowed for higher prescribed MME per day. Given that higher doses are associated with higher overdose rates (3), limiting prescribed MME per day or requiring prior authorization or step therapy for high-dose opioids may facilitate better adherence to Centers for Disease Control and Prevention prescribing recommendations. Because formulary coverage directly affects prescribing, our study suggests that formularies present an underused opportunity to restrict opioid prescribing.

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