February 16, 2018

The Honorable Orrin G. Hatch
Chairman, U.S. Senate Committee on Finance
219 Dirksen Senate Building
Washington D.C. 20510

The Honorable Ron Wyden
Ranking Member, U.S. Senate Committee on Finance
219 Dirksen Senate Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden:

Thank you both for your Committee's leadership on the ever-growing opioid abuse epidemic. Drug overdoses are the leading cause of accidental death in the United States. This Committee has played a significant role in addressing the critical and heartbreaking opioid and substance use disorders, which are eroding the foundation of many communities across the country.

We appreciate the opportunity to offer policy recommendations to assist this Committee's efforts to work with federal agencies and States to address the root causes that lead to, or fail to prevent, opioid use disorder (OUD) and other substance use disorders (SUDs). Based on our company's background, and our ongoing work with federal and State health care agencies and health care providers nationwide, our recommendations will focus on the three questions where we feel data and analytics can make the greatest strides towards improving access to and quality of treatment to combat this national emergency:

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 outcome?

CMS should continue to support states as they look to leverage federal Medicaid financing, other federal grants, and State funding streams to provide a more comprehensive array of SUD services. States are trying to design payment incentives that align with specific performance metrics to enable the identification and dissemination of effective policies and programs. This Committee can help states in their efforts to ensure beneficiaries receive the appropriate prevention and treatment to improve patient outcomes by:

- **Accelerated Approval for SUD Treatment in IMDs:** Encouraging CMS to grant accelerated approval for States' requests to leverage Medicaid matching funds for SUD treatment in institutions of mental disease (IMDs) for stays up to 30 days. Historically, the federal IMD exclusion has prohibited the use of federal Medicaid financing for mental health and substance abuse disorder residential treatment services in facilities with greater than 16 beds. The May 2016 final Medicaid managed care rules eased that restriction by allowing Medicaid coverage for stays of up to 15 days in an IMD of any size when it is provided as an in-lieu of service.

- **Supporting Low Intensity Residential Services:** Supporting CMS's work to assist States in their efforts to add low intensity residential services (e.g. substance abuse halfway houses to prevent relapse following completion of treatment) as covered Medicaid benefits, under different State Plan and waiver authorities (e.g. 1915(b)(3) and 1115 demonstration waiver authority).

- **Cause & Effect Reporting:** Continuing to support States in their efforts to build out the data management infrastructure and reporting/analytic capabilities to provider better insight into the cause and effect of policy decisions and funding options to better understand opportunities for intervention and education. States recognize they have gaps in addiction services coverage; however, they struggle with where to appropriate funding for treatment facilities based on the combination of local need and determining which facilities have the best outcomes. We would recommend the Committee consider allocating some of the FY2018 and FY2019 funding identified for fighting the opioid epidemic to leverage claims data alongside PDMP data. The goal would be to better understand where patients with SUDs seek treatment, compare health outcomes across these treatment programs (i.e. are these programs effective?), identify gaps in treatment, and communicate this information to providers and patients.

USE CASE

Using advanced analytics, the Commonwealth of Virginia tackles its substance use epidemic by mapping provider coverage to need for addition services. The Commonwealth's Department of Medical Assistance Services (DMAS) is flooded with data from multiple programs, including emergency department, opioid, and heroin abuse data, which makes it difficult for the Agency to match patients with the most appropriate services and providers. DMAS can review fresh provider network information daily to help get addiction recovery assistance to the people who need it more quickly. By identifying where substance abuse treatment services were offered, the Commonwealth then developed policies and leveraged funding to cover more community-based addiction recovery services, such as medication-assisted opioid treatment. Data management and analytics allows the Commonwealth to identify beneficiaries suffering from SUDs and match them with the most appropriate community treatment program to increase positive patient outcomes.

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

Health professionals recognize the important role they play in the fight against the opioid epidemic. The challenge they face is having to balance prescribing the appropriate medical treatment plan for their patients while recognizing some patients are at a higher risk to develop opioid (or even heroin) addiction. Health professionals oftentimes are not aware of macro-level prescribing patterns, nor are they always aware of where else their patients are receiving care. State PDMPs provide insight into some of these prescribing and patient behaviors that are indicative of opioid misuse, but are plagued with latency issues and incomplete data, which makes meaningful analysis and reporting difficult (without the addition of other, complementary, data).

CMS could augment its data infrastructure to quickly and more accurately identify Medicare and Medicaid providers who exhibit unusual prescribing patterns. More specifically, we ask the Committee to support the following recommendations:

- **Strengthen Data Management & Analytics for Prescriber Outlier Identification:** Encouraging CMS to continue to strengthen its internal data management and analytic capabilities to more quickly identify unusual prescribing for Medicare providers that do not appear to be in alignment with evidenced-based prescribing guidelines. This could include

collecting PDMP participation data from States, which could be matched against continuing medical education to determine program effectiveness.

- **Leverage Additional Data in the Development of Risk Indicators:** Encouraging CMS to continue to work with States in their design of Section 1115 demonstration waivers to encourage adoption of data management and analytics capacities that leverage additional data sources (e.g. claims) to allow for the development of health risk indicators and predictive outcome analytics and the design of payment models that aim to incentivize providers to break the cycle of dependence.

USE CASE

SAS is working with the State of North Carolina's Government Data Analytics Center (GDAC) and the State's Department of Health and Human Services (DHHS) to develop a multi-pronged approach to create an analytics and reporting repository that will give DHHS valuable insights to proactively address the opioid crisis. This includes enhancing the State's ability to link records within the state's PDMP, called the Controlled Substance Reporting System (CSRS), to improve the quality and reliability of the information that stakeholders are getting out of the system and enable the development of more accurate reporting and analytics. DHHS is developing and implementing an analytic and predictive risk model to more quickly identify unusual prescribing and utilization patterns and identify patients who are at risk for developing substance abuse disorder. This will allow DHHS to potentially identify the characteristics and behaviors associated with opioid abuse and/or criminal activity to break the cycle of dependence.

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

Opioid addiction, overdose, and death have become all too common in our communities. Federal, State, and local governments recognize their role in combatting this public health crisis. However, Congress, federal agencies, and states do not have a holistic view of the root causes of the problem. This hinders the ability to develop good policies, tempering effectiveness. Those agencies trying to solve pieces of the puzzle have data management challenges because the information they have access to is often partial, fragmented and not actionable. To make informed decisions, federal and State agencies need data to understand what is happening, adjust the policy, and motivate physicians and patients to change their behaviors. Furthermore, those same agencies are responsible for multiple funding streams for opioid-related activities but often do not coordinate efforts, nor examine the programs, from an enterprise level. Federal and State agencies recognize the need to assess the effectiveness of their programs and policies, but to date, have struggled with data quality issues and latency of the data to be able to identify root causes/risk factors for the epidemic. More specifically, we ask the Committee to support the following recommendations:

- **Improve Real-Time Surveillance:** Improve real-time surveillance of the opioid crisis through policies that strengthen the current data collection activities at the federal, State, local and tribal levels. At the federal level, this could include an integrated data sharing platform, hosted within CMS, that brings together publicly available data with agency-specified data (e.g. administrative claims data) for real-time data analytics. For example, identify Medicare and Medicaid policies and interventions that effectively reduce drug abuse to better direct programmatic funding.

- **Develop Data Collection Guidelines:** CMS could work with the Office of the National Coordinator for Health Information (ONC) to develop standards and issue guidance to States to improve data collection, analyses, outcomes and evaluation related to substance abuse disorders and treatments.

State Prescription Drug Monitoring Programs (PDMPs)
States' PDMPs are leading to changes in prescribing behaviors, but they are not solely the panacea to the opioid epidemic and we have yet to see them impact substance abuse deaths. States are looking to leverage other data sources (e.g. Medicaid claims data) alongside PDMP data and use analytics to more accurately identify what contributes to substance abuse disorder and who is at risk for addiction. This helps States identify prescribing trends and better analyze their policies/programs effects on health outcomes, with the hope to prevent opioid use in the first place.

States have made improvements to PDMPs to make them more user-friendly for health care providers. Despite the increase in the adoption of state PDMPs, less than half are actively (and meaningfully) exchanging that information with hospitals and provider organizations. Providers are required to enter data into multiple health information technologies, and often resist using PDMPs because they reside outside their clinical workflows. Studies show PDMP data needs to be real-time and accessible to health care providers at the point of care to improve patient safety and health outcomes. States are beginning to integrate PDMP data with providers' electronic health records and/or state health information exchanges (HIEs). This will provide actionable insights from PDMPs into the hands of clinicians.

Despite these improvements at the State level, federal agencies do not have a uniform way of accessing PDMP data cross States as the data platforms differ by State and federal agencies do not have a comprehensive national PDMP data set. State PDMPs are currently using different versions of the nationally recognized data transmission formats and timeliness of PDMP reporting varies by states. As a result, the quality of the data in PDMPs is of concern as the data sets are often missing or incomplete.

There are several policy areas that could help the Federal government address the opioid epidemic; however, these policies are not directly under your Committee's jurisdiction. We wanted to bring these to your attention as these policies would allow CMS improve access to data to help States in their efforts to both focus on the prevention of substance use disorder and identification of those patients who are at risk to develop a substance use disorder. These policy recommendations include:

- **Take immediate action to require States to submit their individual PDMP data to CMS.** This would help CMS have a comprehensive picture of prescribing and dispensing patterns through an advanced analytics environment.

- **Develop standardize data elements and formats for States to require: implement one standard transaction format for reporting PDMP, one standard transaction for inquiry and one standard transaction for response.**

- **CMS should work with ONC and SAMSHA to continue to determine best practices for standardizing the use of PDMP programs.** This could include funds for federal agencies to provide technical assistance to States to assist in this required submission of PDMP data.

Thank you both again for your commitment to help solve this nation's top public health crisis. We appreciate your consideration of our recommendations, and we would welcome the opportunity to discuss any recommendation in additional detail at your earliest convenience.

If you have any questions, please do not hesitate to contact Brian Vanderbloemen in our Arlington, Virginia office at Brian.Vanderbloemene@sas.com or reach out to me directly at Steve.Kearney@sas.com or by phone at (919) 457-7075.

Sincerely,

Steve Kearney, PharmD
Medical Director and Senior Manager
SAS US Government

cc: The Honorable Richard Burr
Member, U.S. Senate Committee on Finance