



February 23, 2018

The Honorable Orrin Hatch
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The National Coalition on Health Care applauds you for seeking “recommendations along the continuum that spans from addressing the root causes that lead to, or fail to prevent, opioid use disorder and other substance use disorders to improving access to and quality of treatment.” This letter outlines NCHC’s initial recommendations, responsive to this request.

NCHC is a nonpartisan, nonprofit organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers, and groups representing consumers, patients, women, minorities, and persons with disabilities. The Coalition is committed to advancing - through research and analysis, education, outreach, and informed advocacy – an affordable, high-value health care system for patients and consumers, payers, employers, and taxpayers.

Opioid Use Disorder (OUD) and Substance Use Disorders (SUDs) in general are exacting an enormous toll in lives and in increased economic burden. In 2016, 64,000 Americans lost their lives to drug overdoses alone,¹ a horrifying level of impact that could well be eclipsed by longer-term increases in other SUD-related sources of mortality. According to the Altarum Institute, the combined economic costs of substance abuse since 2001 have exceeded \$1 trillion, inclusive of health spending as well as lost wages and productivity. \$500 billion in additional costs are expected within the next three years alone – if the epidemic remains on its current course.²

Unfortunately, turning the tide will not be easy. The roots of this crisis are complex, and any successful response must be multifaceted. Providers, payers, and public programs should be re-examining their practices and policies to promote adherence to CDC guidelines regarding opioid use, namely that opioids should not be routine or first- line treatments for chronic pain

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and that prescriptions should be at the lowest effective dose for the shortest possible time. Effective public health and prevention initiatives, alternatives to addictive pain medications, and affordable access to treatment are also indispensable. Finally, any cost-effective strategy must look beyond health care and policing, toward the employment, housing, and educational opportunities that are associated with lower rates of substance abuse.

Successfully implementing such a strategy will take time. It will require sustained leadership across the public and private sectors over a period of years. But these facts only make it more urgent that policymakers lay the foundation for success now.

NCHC recommends the following immediate steps:

Implement the Comprehensive Addiction Recovery Act's (CARA's) Lock-In Provisions: 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.³ Section 704 of CARA allows Medicare Part D plans to implement a drug management program for at-risk beneficiaries. NCHC supports prompt implementation of this important reform.

Require Electronic Prescribing for Controlled Substances: Inappropriate prescribing of opioid drugs has played a well-documented role in the current crisis.⁴ Certain non-opioid medications that interact with opioids like gabapentinoids and benzodiazepines are driving increased overdoses.⁵ Tracking prescriptions and prescribing patterns is a necessary first step toward preventing this kind of avoidable public health emergency in the future. Unfortunately, permitting paper prescriptions opens the door to abuse, diversion, and fraud. NCHC supports HR 3528, *the Every Prescription Conveyed Securely Act*, which requires electronic prescribing for controlled substances under Medicare Part D.

Encourage Integration of Behavioral Health with Primary Care: In the United States, the specialty behavioral health infrastructure and workforce is simply too small to successfully address today's epidemic alone. Evidence-based prevention, screening, assessment, and treatment for both substance use disorders and comorbid mental health conditions must be fully integrated with the rest of health care, particularly primary care. As the first and 2nd largest payers for care, Medicare and Medicaid must support and encourage this integration. Evidence-based SUD interventions, like Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT), should be more broadly available through better integration between primary care and behavioral health. To that end, we support

- establishing incentives for additional physicians, nurse practitioners, clinical pharmacists and physician assistants to receive training in these interventions;
- providing additional, targeted funding for the development, testing, and endorsement of meaningful performance measures related to behavioral health/primary care integration, inclusive of SUD screening and treatment;

- incorporating strong behavioral health metrics into existing CMS performance measurement initiatives, in coordination with other payers and multi-payer measure alignment efforts like the Core Measures Collaborative; and
- permitting Federally Qualified Health Centers and other providers to bill state Medicaid programs for both behavioral and physical health care visits on the same day.

We encourage the Committee to work with CMS and the states to assure immediate administrative action wherever possible, and pursue prompt legislative solutions if necessary.

Reform of the Medicaid Institutes of Mental Disease (IMD) Payment Exclusion: An outdated provision of the 1965 federal law establishing Medicaid bars state Medicaid programs from covering adult inpatient or residential addiction treatment in facilities with more than 16 psychiatric beds. Recent Medicaid guidance now allows managed care plans to furnish up to fifteen days of treatment per month in lieu of other Medicaid-covered services,⁶ and a handful states have received waivers to cover SUD treatment on a broader basis. However, when an epidemic of substance abuse is sweeping the nation, an update to the underlying statute is urgently needed. NCHC supports S. 1169, *the Medicaid CARES Act*, which would give all states the option of covering adult residential treatment as part of a full continuum of SUD services. Facilities would have to be accredited, with an average number of no more than 40 beds.

We greatly appreciate that you have sought out stakeholders' input as you craft legislative responses to this pressing national crisis. Please do not hesitate to contact NCHC's Policy Director, Larry McNeely, at lmcneely@nchc.org if you have questions regarding this letter or related issues.

Yours truly,



John Rother
President and CEO

¹ "Overdose Death Rates," National Institute on Drug Abuse, September 2017, <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.

² "Economic Toll Of Opioid Crisis In U.S. Exceeded \$1 Trillion Since 2001," Altarum, February 13, 2018, <https://altarum.org/about/news-and-events/economic-toll-of-opioid-crisis-in-u-s-exceeded-1-trillion-since-2001>

³ Douglas C. McDonald and Kenneth E. Carlson, "Estimating the Prevalence of Opioid Diversion by Doctor Shoppers in the United States," *PLOS One*, July 7, 2013, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0069241>.

⁴ "E&C Continues to Probe National Distributors About Alarming Number of Opioids in West Virginia," Energy and Commerce Committee, U.S. House of Representatives, February 15, 2018, <https://energycommerce.house.gov/news/press-release/ec-continues-probe-national-distributors-alarming->

[number-opioids-west-virginia/](#); “Physicians are a leading source of prescription opioids for the highest-risk users,” Centers for Disease Control and Prevention, March 3, 2014, <https://www.cdc.gov/media/releases/2014/p0303-prescription-opioids.html>.

⁵ Christopher M. Jones and Jana K. McAninch, “Emergency Department Visits and Overdose Deaths From Combined Use of Opioids and Benzodiazepines,” *American Journal of Preventive Medicine* (Volume 49, Issue 4), October 2015, [http://www.ajpmonline.org/article/S0749-3797\(15\)00163-4/fulltext](http://www.ajpmonline.org/article/S0749-3797(15)00163-4/fulltext).

⁶ “Medicaid: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies,” Report to the Co-Chair, Caucus on International Narcotics Control, U.S. Senate, United States Government Accountability Office, August 2017, <https://www.gao.gov/assets/690/686456.pdf>.