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COMBATING THE OPIOID CRISIS: IMPROVING THE ABILITY OF MEDICARE AND MEDICAID TO PROVIDE CARE FOR PATIENTS

WEDNESDAY, APRIL 11, 2018

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 3:25 p.m., in Room 2322, Rayburn House Office Building, Hon. Michael Burgess, M.D. [chairman of the subcommittee] presiding.

Present: Representatives Burgess, Guthrie, Upton, Shimkus, Blackburn, Latta, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Carter, Walden (ex officio), Green, Schrader, Kennedy, Cardenas, Eshoo, Pallone (ex officio).

Also Present: Representatives Tonko and Peters.

Staff Present: Adam Buckalew, Professional Staff Member,

Health; Karen Christian, General Counsel; Paul Edattel, Chief Counsel, Health; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Associate, Health; Ed Kim, Policy Coordinator, Health; Drew McDowell, Executive Assistant; James Paluskiewicz, Professional Staff, Health; Mark Ratner, Policy Coordinator; Jennifer Sherman, Press Secretary; Austin Stonebraker, Press Assistant; Josh Trent, Deputy Chief Health Counsel, Health; Everett Winnick, Director of Information Technology; Jacquelyn Bolen, Minority Professional Staff; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Senior Health Counsel; Rachel Pryor, Minority Senior Health Policy Advisor; Samantha Satchell, Minority Senior Policy Analyst; Theresa Tassey, Minority Health Fellow.

Mr. Burgess. The Subcommittee on Health will now come to order. The chair will recognize himself 5 minutes for the purposes of an opening statement.

This afternoon the Health Subcommittee marks its third in a series of hearings this spring on legislation addressing the opioid epidemic. By the end of this week's hearing we will have considered a total of 67 opiate-related bills.

In our last hearing we discussed 25 public health and prevention-focused bills over the course of 2 days. Today the subcommittee will be breaking a record by examining 34 bills centered around improving Medicaid and Medicare programs at the Center for Medicare and Medicaid Services.

While committee members on both sides of this dais have put in a lot of time and thought in developing these bills, a majority are still in discussion draft form. And this is a feature not a bug. It is intentional. We seek to explore promising ideas while collecting important feedback from Members, providers, plans, patients, and other stakeholders.

Some of these bills challenge the status quo for some practices within Medicaid and Medicare. But with more than 110 Americans dying daily from an opiate overdose, we must be willing to ask hard questions and seek solutions.

With the crisis devastating our country and eroding our economic productivity, all of us must be willing to take a fresh and fair look at each of the policies presented today. We should think creatively

about how to help strengthen Medicaid and Medicare's ability to combat this scourge of opiate abuse because without adequate tools and accountability our largest public players will be unable to handle the challenge that is before them.

So today we are joined by Kimberly Brandt, who has been charged to lead the efforts addressing the opiate crisis at the Center for Medicaid and Medicare Services.

Ms. Brandt, thank you for being here testifying before us and providing your insights on ways that we can partner together to turn the tide in this fight.

Tomorrow we will hear from individuals representing healthcare providers, health plans, behavioral health specialists who provide the critical treatment to Americans with opiate addiction and substance use disorder. It is my expectation that our conversations will help us adopt effective policies that have a meaningful impact.

One issue that has repeatedly come up is our physician workforce. Congress can pass bills to increase access to evidence-based treatment, but if we do not have enough physicians equipped with proper tools and training we will not have the sufficient capacity to provide treatments for individuals suffering from this disorder.

To this end, I have worked on draft legislation that will provide Congress with more robust transparency about how graduate medical education dollars under current law are helping equip the next generation of doctors to better identify and treat patients with substance use disorder.

Prescription drug monitoring programs are important informational tools that help track prescriptions and identify patients at risk of overdosing on opiates. The Medicaid Partnership Act would require State Medicaid programs to integrate these monitoring programs into Medicaid providers' and pharmacists' clinical workflows while establishing basic criteria for qualified prescription drug monitoring programs. I think it is common sense to ask one of our largest payers to access one of our most powerful data tools to care for some of our most at-risk patients.

Another useful tool already in place in many State Medicaid programs are pharmaceutical homes. The Medicaid Pharmacy Home Act would codify the commonsense idea of requiring States to have provider and pharmacy assignment programs that identify at-risk Medicaid beneficiaries and set reasonable limits on the number of prescribers and dispensers that they can utilize. Given what we know, it is good medicine for all of us to ensure that States are using this effective approach to identify at-risk beneficiaries.

We certainly have much to consider, but we are building on years of previous bipartisan efforts, and we know our work is important to our families and our communities and our constituents affected by this epidemic.

Before I close, I want to touch on the growing fear that I am hearing from many patients suffering from a chronic pain condition who have actually been successfully managed by long-term opiate administration, especially when these drugs are drugs of last resort.

I anticipate some discussion on the recent CMS rule to limit the amount and length of opiate prescriptions.

Our effort to overcome this crisis is vital, but I want us to keep these patients in mind and not, as we say down south, over torque the bolt. I have a submission from The New York Times that I would like to add to the record for this.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Burgess. Again, I want to thank our witness for testifying today and our witnesses tomorrow. I look forward to learning from your insights.

And I want to yield time to the vice chairman of the Health Subcommittee, Mr. Guthrie of Kentucky, for his statement.

[The prepared statement of Mr. Burgess follows:]

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Mr. Guthrie. Thank you, Mr. Chairman.

I appreciate the chairman's diligent efforts to ensure our committee responds quickly and meaningfully to our Nation's opioid crisis. Just last week I heard another awful story about how the destructive path of the opioid crisis harmed a family in Cecilia, Kentucky, all caused because of a motorcycle accident that led to back surgery that led to addiction.

I would like to ask unanimous consent to submit a number of letters in the record on how pharmacists and the Pharmacy and Medically Underserved Areas Enhancement Act can help address these in the opioid epidemic.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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Mr. Guthrie. Thank you, Mr. Chairman. I yield back.

[The prepared statement of Mr. Guthrie follows:]

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Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from Texas, Mr. Green, the ranking member of the subcommittee, 5 minutes for an opening statement, please.

Mr. Green. Thank you, Mr. Chairman.

This is a third in a series of hearings on the opioid epidemic and its impact on individuals, families, and communities in our Nation. Our committee has heard from Federal agencies and stakeholders on the terrible cost of opioid abuse, which takes the lives of 115 Americans each day and is estimated to cost our national economy over $78 billion annually.

Today's hearing will focus on the role that Medicaid and Medicare play in providing health coverage for Americans in need of comprehensive treatment and recovery services. Medicaid is the largest payer for behavioral health services, mental health, and substance use disorder, or SUD, in the United States. Medicaid delivers care to 4 of 10 nonelderly adults with opioid use disorder.

Nearly 12 percent of adults enrolled in Medicaid have SUD. Adults on Medicaid are more likely than other adults to receive substance use disorder treatment.

Medicaid plays a critical role for children either suffering from substance use disorder or born with neonatal abstinence syndrome, NAS. Medicaid covers more than 80 percent of the NAS babies nationwide.

Medicaid expansion provided under the Affordable Care Act has

played a critical role in providing comprehensive coverage for Americans suffering from substance abuse disorder who live in 31 States that have expanded.

Data recently published by the Center for Budget and Policy Priorities found that under Medicaid expansion the uninsured rate among people with opioid-related hospitalizations fell dramatically in States that expanded, from 13.4 percent in 2013, the year before the expansion took effect, to just 2.9 percent 2 years later.

For example, after Kentucky expanded Medicaid in 2014, Medicaid beneficiaries' use of substance use treatment services in the State rose by 700 percent. My home State of Texas and 18 other States continue to refuse to expand Medicaid, denying millions of Americans the comprehensive services and continuum of care necessary to treat and recover from opioid addiction and other substance use disorders. Medicaid expansion includes substance use services as mandatory benefit.

The reality is that if folks want to save lives of these individuals, we have got to focus first on getting those people health insurance so they can access treatment. Continuity of comprehensive health insurance makes the difference between life and death.

Two weeks ago the Texas Department of State Health Services released a report that found opioid overdoses as the leading cause of death for new mothers in our State, with the most occurring after a pregnant woman's Medicaid benefits end 60 days after delivery.

Last year, I introduced the Incentivizing Medicaid Expansion Act,

H.R. 2688, in order to incentivize States to provide critical Medicaid coverage for Americans in need and to avoid the kinds of tragedies that have led to the rising rate of maternal mortality in our home State. My legislation would guarantee that the Federal Government covers 100 percent of expansion costs for the first 3 years for States that have not yet expanded and no less than 90 percent afterwards.

Medicare also plays an important role in the opioid crisis. According to SAMHSA, more than one million seniors suffered from substance use disorders in 2014. While Medicare part B and part D provide SUD treatment services, there are significant gaps in Medicare's benefits, including no coverage for substance abuse treatment at opioid treatment programs or methadone clinics.

We also need to ensure that Americans on Medicaid or Medicare are not overprescribed opioids. HHS' Office of Inspector General found that more than 500,000 part D beneficiaries received high amounts of opioids in 2016, with the average dose far exceeding the manufacturers' recommended amount. Additionally, nearly one-third of the beneficiaries in Medicare part D or C had an opioid prescription in 2016.

Before closing, I would like to voice my concern over the number of bills and discussions drafts being considered at the hearing, 34 in total. Never in my time on Energy and Commerce have we had legislative hearings on so many bills and drafts. Combined with the bills and discussion drafts from the two previous opioid hearings, we are looking at over 70 pieces of legislation. I am concerned that the

majority is planning to mark up legislation later this month, and that has not been fully vetted by our staffs, stakeholders, and the appropriate Federal agencies.

The opioid crisis is hitting communities throughout America regardless of location or political affiliation. We can and must advance opioid legislation in a bipartisan manner that the American people deserve. I ask for the majority to work with us and provide the necessary time to vet legislation being considered and ensure the anticipated markup will not become a partisan exercise.

Thank you, and I yield the balance of my time.

[The prepared statement of Mr. Green follows:]

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Mr. Burgess. The chair thanks the gentleman.

The chair would just observe that the gentleman has never served with the current chairman before. And you may have recognized by now you do have a very active and an activist chairman and that will continue for the balance of the year.

Mr. Green. Well, I like activism, Mr. Chairman, but I also like substance.

Mr. Burgess. There is substance, I guarantee you, with these 34 bills.

The chair recognizes the chairman of the full committee, Mr. Walden, for 5 minutes for an opening statement.

The Chairman. With these 34 on top of the other 24 on top of the other 6 or 7, we are going to have our hands full of good legislation, because today marks our third and final legislative hearing this spring aimed at advancing targeted, timely, and bipartisan legislative solutions to help combat the opioid crisis.

This committee has already been instrumental in working in a bipartisan manner to devote a record -- let me underscore record -- amount of Federal resources toward the opioid epidemic, namely through passage of the CARA and 21st Century Cures Act last Congress. My colleague here, Fred Upton, led the effort with Diana DeGette to get that done. This hearing continues the work to address the crisis that has impacted virtually every neighborhood, every community, and so many families across our country.

You know, at roundtables I have done in my district, across

Oregon, most recently in Pendleton and Madras, I have met with people on the front lines of this fight and with those who have lost a friend, lost a child, lost a sister, lost a loved one, lost a neighbor. These meetings have been crucial to my efforts to put forth concrete solutions to stem the tide and save lives, and I am not alone doing these roundtables around the country.

With more than 100 Americans estimated to die every day from opioid overdoses, we simply have to do everything within our power. We must continue to push forward. And I would respectfully ask everyone involved, stakeholders and Members of Congress alike, to push beyond our comfort zones and think creatively and boldly about how we can help, because the status quo is simply not acceptable. The unprecedented scope of this crisis requires an unprecedented response, and that is what we are able to provide at the Energy and Commerce Committee.

To that end, over the span of 2 days, we will consider 34 bills from Members on both sides of the aisle. These bills have a common theme: They seek to improve the roles Medicaid and Medicare can play in helping combat this crisis. This marks the largest numbers of bills noticed in a legislative hearing before this committee.

But the number and scope of the bills helps underscore how important this topic is to all of us and how many good ideas there are to help patients. While considering this many bills does require some extra work on behalf of the staff and our members, I think we should see this as not an inconvenience, but rather as an opportunity.

Just look at how many promising ideas there are to help patients who are served by these two programs who represent roughly one in three Americans. Certainly both programs play key roles in identifying at-risk beneficiaries, providing treatment, and decreasing overdose deaths.

The bills we will consider today cover a range of important issues, including provisions to remove barriers to treatment, improve data to identify and help at-risk patients, provide incentives for greater care coordination and enhanced care. Many of the bills before us build on efforts in Medicaid and Medicare that are already yielding positive benefits for patients and reducing dependency or misuse of opioids.

As we move forward, we look forward to stakeholders and others providing feedback on these proposals. The input of the Congressional Budget Office will also help shape our decisionmaking on several pieces of legislation before us today.

But our aim remains the same: moving through committee in regular order to advance legislation to the House floor before the Memorial Day recess. That is our goal.

We have seen announcements in sister committees recently as they are also developing and advancing legislation, and we look forward to continuing our work with them to get a robust bipartisan package of proposals to the White House for signature of the President in the coming months.

The urgency of the crisis demands an urgent response, and the

challenges facing our communities demand action now.

So I would like to thank our witnesses for taking time to share their expertise with us today and tomorrow and for Members on both sides of the aisle for making this fight a top priority.

With that, I would yield the balance of my time to my friend and colleague from Tennessee, Mrs. Blackburn.

[The prepared statement of The Chairman follows:]

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Mrs. Blackburn. Thank you, Mr. Chairman, and thank you, Dr. Burgess, for the hearing on these issues.

There are two components that I am looking forward to. And I will tell you, Ms. Brandt, I appreciate the work of the administration to support the State Medicaid programs in their efforts to examine combat these programs.

Tennessee's TennCare program recently implemented some new policies, and I had some good discussion this past weekend with some of our State legislators and some physicians who are hard at work on that with a 5-day limit on the prescriptions, prior authorization for any refills, a robust buyback program.

And I am looking forward also to discussing with you the IMD exclusion. Some of those that treat substance abuse have talked about this as a barrier to getting individuals into beds, into the treatment that they need.

So we really appreciate the work that you all are doing and look forward to getting the legislation across the finish line.

I yield back.

[The prepared statement of Mrs. Blackburn follows:]

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Mr. Burgess. The gentlelady yields back. The chair thanks the gentlelady.

The chair yields to the gentleman from, New Jersey, Mr. Pallone, ranking member of the full committee, 5 minutes for an opening statement, please.

Mr. Pallone. Thank you, Mr. Chairman.

Today's hearing is the third in a series to address the opioid and substance abuse crisis that is ravaging communities across the country, and our focus today is on the role of the two largest public health insurance programs, Medicaid and Medicare.

A lot needs to be done to address this epidemic, but we should focus our time on what is most meaningful and impactful. While I support addressing this crisis through a bipartisan process, I am concerned that the sheer quantity of bills before the committee today and the chairman's extremely ambitious timeframe will not leave us much time to get these policies right.

Today we will discuss 34 bills in one 2-day hearing, the vast majority of which the members of the committee have seen for less than a week. So I am concerned that many of the proposals have not been introduced. Most have not had the benefit of technical assistance or a CBO score. In fact, CMS' own testimony today I don't believe discusses any of the bills under consideration.

So at times to me this process feels more like an opioids media blitz than a thoughtful discussion about our national public health crisis, and this is not the deliberative process that the members of

this committee and the American people deserve.

But with that important caveat aside, I will say that many of the proposals we are examining today have merit and strive to address a number of policy problems that Medicaid and Medicare face in combating the opioids epidemic. In Medicaid, we are considering legislation that would strengthen the continuity of coverage that people receive, particularly vulnerable populations, like adults and children leaving the justice system and former foster youth. And I know that the best way to combat the opioids crisis is for people to have access to strong and consistent health coverage that provides the treatment they need.

You also will hear about policies that invest in our providers on the ground, and our State Medicaid infrastructure helps States to build on what works, like Medicaid health homes, and promote new models of care to expand treatment capacity of providers.

We are also looking at complex issues related to how our Medicaid programs track and dispense prescribing of opioids and relieving barriers to lifesaving treatment, like naloxone and MAT. And I think we could do even more in this area. There are bills to improve quality and data on how this crisis impacts Medicaid that will also be important to know in the coming years.

In addition, Mr. Chairman, there is legislation related to repealing the so-called IMD exclusion for a 5-year period. Medicaid IMDs are one very important piece of the treatment puzzle that States are incorporating into their delivery systems already through Medicaid's special Substance Use waivers. This is an example of a bill

that needs a very thoughtful approach so we do not hurt the efforts that are already occurring in States today.

And we are also considering legislation regarding the role of Medicare parts B and D to address the rising epidemic of opioid overprescription and misuse among seniors. For example, we will discuss legislation under Medicare part B to expand opioid disorder treatment options through telehealth and also legislation under part D to ensure e-prescribing is utilized when prescribing controlled substances. And we will also discuss legislation to create an alternative payment model to incentivize the delivery of high-quality, evidence-based opioid treatment service for Medicare beneficiaries.

These bills are important because evidence suggests that opioid use among older adults is a significant and growing problem. According to the OIG, more than 500,000 part D beneficiaries received high amounts of opioids in 2016, with the average dose far exceeding the manufacturers' recommended amount.

So I want to be clear, this committee must focus on meaningful proposals that will address the opioid crisis. I intend to oppose any bill that has nothing to do with opioids, that makes the problem worse, or that is simply not ready and vetted in the time that we have allotted. Our policy goal should always be to first do no harm, and without the proper time to vet the legislation before us I can't be sure that we are meeting that goal.

For instance, I have significant concerns regarding one of the discussion drafts to add a pain assessment to the Welcome to Medicare

physical. While well intentioned, I am concerned that this bill could actually exacerbate our opioid crisis.

I have heard from numerous stakeholders in the medical community that a similar approach adopted by the Joint Commission in 2001 to treat pain as a fifth vital sign actually contributed to the opioid epidemic, because by requiring healthcare providers to ask every patient about their pain and incentivizing aggressive management of pain these measures may have resulted in the overprescribing of opioids.

So finally, Mr. Chairman, I hope to work with my colleagues to address these concerns so that we can all support concrete and thoughtful legislation that will actually help address the crisis. And thank you again. I yield back.

[The prepared statement of Mr. Pallone follows:]

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Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

That concludes member opening statements. The chair reminds members that, pursuant to committee rules, all members' opening statements will be made part of the record.

And we do want to thank our witness for being here this afternoon, staying with us through the previous full committee hearing, taking the time to testify before the subcommittee.

Today our witness will have the opportunity to give an opening statement, followed then by questions from members. The panel today, of course, will be Dr. Kimberly Brandt, the Principal Deputy Administrator for Operations for the United States Centers for Medicare and Medicaid Services.

We appreciate you being here today, Dr. Brandt, and you are recognized for 5 minutes to summarize your opening statement, please.

STATEMENT OF KIMBERLY BRANDT, PRINCIPAL DEPUTY ADMINISTRATOR FOR OPERATIONS, U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. Brandt. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for inviting me to discuss CMS' work to address the opioid epidemic.

CMS understands the magnitude and impact the opioid epidemic has had on our communities and is committed to a comprehensive and multipronged strategy to combat this public health emergency.

As the principal deputy administrator for operations at CMS, I am charged with addressing cross-cutting issues that affect our programs, with the efforts to fight the opioid epidemic being one of our agency's and the administration's top priorities.

Over 130 million people receive health coverage through CMS programs, and the opioid epidemic affects every single one of them, as a patient, family member, caregiver, or community member. This theme has been repeated throughout multiple stakeholder listening sessions that CMS has facilitated to discuss best practices and brainstorming solutions.

As a payer, CMS plays an important role by incentivizing providers to provide the right services to the right patients at the right time. Our work at CMS is focused mainly on three areas: prevention, treatment, and data. Due to the structure of our programs, Medicare part D plan sponsors in State Medicaid programs are well positioned

to prevent improper opioid utilization by working with prescribing physicians. Our job at CMS is to oversee these efforts and to make sure that plan sponsors in States have the tools they need to be effective.

Beginning in 2019, CMS expects all part D sponsors to limit initial opioid prescription fills for acute pain to no more than 7 days' supply, which is consistent with the guidelines set by the Centers for Disease Control and Prevention. Additionally, we expect all sponsors to implement a new care coordination safety edit that would create an alert for pharmacists when a beneficiary's daily opioid usage reaches high levels. Pharmacists would then consult with the prescriber to confirm intent.

Thanks to recent action taken by Congress, CMS now has the authority to allow part D plan sponsors to implement lock-in policies that limit certain beneficiaries to specific pharmacies and prescribers. We recently finalized a proposal to integrate lock-in with our Overutilization Monitoring System, or OMS, to improve coordination of care. The administration also has put forth legislation to require plan sponsors to implement lock-in policies.

These new tools will add on to existing innovative approaches in part D to track high-risk beneficiaries through OMS and to work with plan sponsors to address outlier prescribers and pharmacies. We have seen a 76 percent decline in the number of beneficiaries meeting the OMS high-risk criteria from when we started this in 2011 through 2017, even at the same time that part D enrollment was increasing.

We also support State efforts to reduce opioid misuse. Medicaid programs can utilize medical management techniques such as step therapy, prior authorization, and quantity limits for opioids. In this year's President's budget, CMS proposed establishing minimum standards for the Medicaid Drug Utilization Review program, a tool that we use to oversee State activities in this area.

In addition to our prevention measures, ensuring that Medicaid and Medicare beneficiaries with substance use disorder have access to treatment is also a critical component to addressing the epidemic. Our aim is to ensure the right treatment for the right beneficiary in the right setting, and we are working to increase access to medication assisted treatment, or MAT, as well as naloxone.

The President's budget also includes a proposal to conduct a demonstration to cover comprehensive substance abuse treatment in Medicare through a bundled payment for methadone treatment or similar MAT. Because current statute limits CMS' ability to pay for methadone, we are focused on ensuring access to other evidence-based MAT.

The administration is also committed to increasing treatment access for Medicaid beneficiaries as well through our 1115 waiver authority. CMS recently announced a streamlined process last November providing more flexibility for States seeking to expand access to treatment. Already we have approved five State demonstrations, which include services provided to Medicaid enrollees in residential treatment facilities.

As this committee knows, ordinarily residential treatment

services are not eligible for Federal Medicaid reimbursement due to the statutory exclusion related to institutions for mental disease or IMDs. Combined with the full spectrum of treatment services, we believe the new residential treatment flexibility is a powerful tool for States, and we look forward to reviewing more requests.

Finally, CMS is utilizing the vast amount of data that we have at our disposal to better understand and address the opioid crisis to share with our partners and to ensure program integrity. This includes active monitoring of trends, sharing prescribing patterns publicly through heat maps, and various other efforts to ensure the effectiveness of prevention and treatment policies.

While CMS has taken numerous steps in the areas of prevention, treatment, and data to address this national epidemic, we know there is more we can do. We appreciate the work that your subcommittee has already done to highlight the importance of addressing this crisis, and we look forward to engaging with you on the legislative solutions that you are developing.

Thank you for your interest in our efforts to protect our beneficiaries, and I look forward to answering your questions.

[The prepared statement of Ms. Brandt follows:]

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Mr. Burgess. Thank you, Dr. Brandt. Thank you for your testimony. Thank you for being here today.

We will move on to the question portion of the hearing, and I would like to first recognize the vice chairman of the committee of the Health Subcommittee, Mr. Guthrie, 5 minutes for your questions, please.

Mr. Guthrie. Thank you very much.

Thank you, Ms. Brandt.

Thank you, Mr. Chairman, for the time.

Thank you for being here, Ms. Brandt.

As you know, there is a lot of interest in the committee on more timely, accurate, and complete Medicaid data, whether it is the Transformed Medicaid Statistical Information System, otherwise known as T-MSIS, or basic Medicaid expenditure data. I think having more timely data is important in the opioid fight for targeting, funding, and understanding how the program is evolving.

One of the bills before the committee would amend the law to allow States only 1 year instead of 2 to submit claims for Federal matching. This deadline does not include adjustments to prior year spending, and the Secretary is allowed to waive the requirement if needed. The requirement in current law was added by Senator Moynihan in 1980. Yet today nearly 99 percent of Medicaid claims are submitted within 1 year.

Ms. Brandt, can you talk about why we would have providers in 2018 that are still taking up to 2 years to submit claims?

Ms. Brandt. Thank you for the question, sir.

As you noted, the T-MSIS system is one of our big priorities at

CMS. Moving to get more accurate and timely data from the States is one of the Administrator's top priorities. We are pleased at this point that we have 49 States, the District of Columbia, and recently, just as of a week ago, Puerto Rico now reporting in. So we have 98 percent of Medicaid data now being reported in.

We share your goal in working to make sure that data is as timely as possible, and one of our challenges right now is ensuring that we have good quality data. As much as the timeliness of the data is an issue, we want to make sure that it is good quality data, as well.

So now that we have the data being reported in, we are working to scrub the data and try and make it as good a quality of data as possible, and we are focusing particularly on the pharmacy files from the data so that we can begin to get information that will particularly help us with the opioid issue because of the State data that they report.

Mr. Guthrie. You said 49 States plus District of Columbia, Puerto Rico, are you using the system. They report within 1 year?

Ms. Brandt. It is the most recent data that they have. It is not all within 1 year, and that is something we are working on with them. It is as timely as the States have the ability to report it.

Mr. Guthrie. But I guess my question is States should be able to do that within 1 year. I know that is one of the bills that we are looking at.

Ms. Brandt. We are working with them to try and get them to transmit it as timely as possible.

Mr. Guthrie. Okay. I want to transition then.

According to NIH, every 25 minutes a baby is born suffering from opioid withdrawal. These are the most vulnerable victims of the opioid epidemic. I, along with Congressman Lujan, plan to introduce a bill on this important issue later this week.

Do you believe that we should facilitate public-private partnerships to provide additional information in support to women, children, and those tasked with their care?

Ms. Brandt. Yes. In fact, CMS is very much dedicated to committing resources to help mothers and their infants struggling with opioid addiction, and we actually approved a State plan amendment for West Virginia back in February to provide additional treatment services and additional resources to help target just that issue.

Mr. Guthrie. Okay. And my final question, as you know, in November of 2017 the President's Commission on Combating Drug Addiction and the Opioid Crisis recommended that CMS revise reimbursement policies that limit patient access to non-opioid drugs used to treat post-surgical pain. Would you please provide the committee an update on where CMS is on the report and specifically on this issue?

Ms. Brandt. I am sorry, can you repeat the part of the question?

Mr. Guthrie. Yes. The President's Commission revised reimbursement policies that limit patient access to non-opioid drugs used to treat post-surgical pain.

Ms. Brandt. So we are committed to working to make sure that we get the right treatment in the right setting, and that certainly includes making sure that we explore non-opioid alternatives to treat

pain, and it is something that we are continuing to look at as an agency to determine how we can best address it from a reimbursement perspective.

Mr. Guthrie. Thank you.

Mr. Chairman, in the spirit of today, I used 4 minutes. So I will yield back a minute.

Mr. Burgess. The chair thanks the gentleman.

The chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for your questions, please.

Mr. Green. Thank you, Mr. Chairman.

Ms. Brandt, thank you for being here.

For years, States and the Federal Government have underinvested in building the necessary infrastructure for provider treatment capacity, workforce development, and wraparound services needed to help Americans suffering from opioid abuse.

Do you agree that the administration should work with States to strengthen the Medicaid coverage and infrastructure and remove the barriers for coverage for people that need the treatment?

Ms. Brandt. Yes. In fact, that is the whole point. As I mentioned in my testimony, we have already been working to give States as much flexibility as possible. We have, as of last November, since then approved five States to have more flexibility through our 1115 waiver authority and are very much committed to continuing to work with States to give them the flexibilities they need so that they can determine the right types of coverage to address the opioid crisis.

Mr. Green. Well, let me ask another question. I just see that CMS is finalizing a rule allowing more State options in the essential health benefits package. Is that essential benefit package going to include mental and substance abuse?

Ms. Brandt. I can't speak specifically to what was just included in the recent benefits package, but I can say that as a whole we have been committed to trying to work with States to allow more support for behavioral health services and those types of support services.

Mr. Green. Well, in the Affordable Care Act there was essential benefits package, and substance abuse and mental health was included in there. We didn't get as much as we should. I know a lot of folks wanted parity, and I support it, but we just couldn't afford it.

But my concern is that we can pass all 70 of the bills, and if we limit States to making sure that they don't cover substance abuse all this paperwork is not going to be worth it. So that is the issue, whether it is through Medicaid or through an insurance policy bought through the ACA. That is my concern, and particularly with the cutting in cost-sharing reduction payments last year.

Do you think CMS plans to continue these efforts to sabotage the ACA marketplaces and endanger healthcare coverage of the millions of Americans? Because, again, if CMS is not making sure that that essential benefits package covers mental health and also substance abuse, it doesn't do us any good to have you and to have these hearings.

If you would take that back.

Ms. Brandt. I will take that back certainly, sir.

Mr. Green. Okay. And I appreciate it.

The other concern, I think, when Congress did recently authorize $6 billion in Federal grants for opioids for 2018 and 2019, this additional funding still falls short of the treatment for Americans struggling with opioid use. Even more troubling is the uncertainty for the new funding stream for 2019. This uncertainty may keep States from fully spending the funds without a commitment of long-term stable funding.

Will CMS urge the Department of Health and Human Services to request increased block grant funding for opioid abuse and other substance use disorders beyond 2019?

Ms. Brandt. Well, as you are probably aware, sir, the President's budget does advocate for block grants to States for more flexibility, and we believe that that is appropriate because that gives States the right to decide the right type of coverage that they need for the opioid crisis and to address their own individual needs.

Mr. Green. Well, and again, one of the reasons we have on the ACA side the essential benefits package, and, frankly, even in Medicaid. Medicaid is the predominant server for mental health and for substance abuse, and if we don't fund those programs, like I said, we can pass all the bills we want, it just won't help us with people being treated out in the street.

And so I appreciate you being here.

And thank you, Mr. Chairman.

Ms. Brandt. Thank you.

Mr. Burgess. The chair thanks the gentleman.

The chair recognizes the gentleman from Michigan, 5 minutes for your questions, please.

Mr. Upton. Thank you, Mr. Chairman.

Ms. Brandt, welcome.

Last week I -- actually it was this week, Monday -- Debbie Dingell, my colleague, we were in west Michigan, and we sat down with a good number of our local mental health providers in my district to talk about pressing issues facing them, how we can be of more help. And I want to flag one of those issues for you and ask that you might be able to work with us on resolving it.

As part of an 1115 waiver, our providers were told that they had to adopt a universal assessment tool called GAIN, G-A-I-N. It is a 77-page assessment tool that takes more than a couple of hours to complete. It is completely duplicative, as every agency already does a comprehensive assessment for each beneficiary. Our providers were told by the Michigan PIHPs that it has to do with the Federal 1115 waiver requirement and that the reason for completing the tool is that we have to do this, we are only the messenger.

And they read some of the questions they are going to actually provide with me later on. Again, I didn't realize this hearing was already scheduled when we sat down Monday afternoon. They are going to share with me that document. But it seems, as they said, they want to practice medicine, often this document turns people away from even continuing the process.

And I just wonder if you can work with us and see if this is really the right approach for them to look at. I know it came, the regs, I think, were written before, but they have been finalized, and it is just something else.

Ms. Brandt. Well, certainly we welcome if you could provide us with the information and the tool I will take it back.

Mr. Upton. I will. I will get it to you next week.

Ms. Brandt. But I will say that one of the Administrator's top priorities has been patients over paperwork, which has been an effort that I know that she has talked to many of you about, to reduce regulatory burden and to try and put patients first over paperwork, hence the name. So it is something that we certainly will go back and look at and appreciate you flagging for us.

Mr. Upton. Great. I will follow up with you on that next week.

The last question I have is a 2018 report notes that psychotherapeutic drugs might account for up to 4 in 10 drugs prescribed to kids in Medicaid. HHS' Office of the IG has recommended that CMS work with the State Medicaid programs to perform utilization reviews on the use of second-generation antipsychotic drugs prescribed to kids.

The Medicaid Drug Improvement Act seeks to codify that recommendation by requiring that every State have a program to protect kids from unnecessary utilization of these powerful drugs, which could place them at a greater risk for substance abuse.

Do you think that such a requirement on States could help CMS better monitor how States are providing care for kids in their State

programs?

Ms. Brandt. Well, we have read the OIG report and are familiar with their recommendations and are committed to working with them to see how we can reduce the high number of drugs that kids would be potentially subject to. We are committed to making sure that kids get the right treatment in the right setting, and we will work with the OIG and with you all to see what we can do to address that.

Mr. Upton. Great. Thank you.

I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from Oregon, 5 minutes, for your questions, please.

Mr. Schrader. Thank you, Mr. Chairman.

Thank you very much, Ms. Brandt, for all the work you are doing at CMS to help deal with the opioid prescription issues. At least I think that we are seemingly getting somewhere. A recent Post article indicated some substantial reduction.

Our medical and dental colleagues are getting on board with prescribing less long-term doses, seems like much in line, might be some incentivized by CMS, but in any case helping drive down the prescription drug abuse problem. And I think that is huge. We work together both in your office and here, frankly, at the practice level. I think that is a big deal.

Are you getting any pushback with regard to some of the guidelines

you are putting out there? It seems to be in line with what I am hearing from my medical colleagues.

Ms. Brandt. I think that the biggest that thing we got comments on when we put out the proposals that we codified in our call letter in our proposed regs was making sure that we were striking the right balance.

And that is something that I have heard several of you as well mention today, and that is making sure that the people who have a chronic illness or cancer or a real need for these types of drugs are able to have the access to them while still making sure that we put the safeguards in place on our side to ensure that those who maybe are just taking it for acute pain or maybe should not be having it at the full level are not at risk of getting addicted.

And I think that is a balance we are striking to get, and that is really where I wouldn't say it is pushback, I think it has just been a constructive dialogue that we have been having with the community on that issue.

Mr. Schrader. It is a work in progress as we work through this. There is some recent evidence that even for chronic pain you can manage -- depending on the person and the situation -- manage chronic pain with modest anti-inflammatories as opposed to having to go to the narcotic.

Ms. Brandt. Correct. And that is why we are looking at other types of MAT and other solutions to be able to work that and try and provide as much flexibility on that as possible.

Mr. Schrader. Would you comment at all on the other, the flip side of this, unfortunately, is that creative people, unfortunately, find alternate ways to satisfy their habits, and there has been a huge rise in the deaths with regard to synthetic opioids and fentanyl, very dangerous, tainted products out there in the market.

What does CMS or how is CMS responding to that and what might we want to help you do.

Ms. Brandt. Well, it certainly is a real risk, and it is something we have taken several steps to address. I mentioned our Overutilization Monitoring System that we have, OMS. That allows us to put alerts in place to tell us when we see a high number of beneficiaries that are using drugs.

So, for instance, if a beneficiary has 90 morphine milligram equivalents or higher for a sustained period of time, say 6 months, and has been using either three or more providers or three or more pharmacies during that time, it puts an alert in place.

I mentioned the 76 percent reduction that we have been able to see as a result of some of those alerts on the part D side, and we are very encouraged by that. But we are really working to put additional edits in place. These are really checks, if you will, that allow it so that the pharmacist, who is obviously a big part of the care team, can work with the provider to ensure that the beneficiary is getting what they need.

I mentioned we have the new 7-day initial fill limit for acute pain. That is, again, intended to make it so that it is part of a

discussion. If there is a need to have something more than that, great, but if not, that really would stop that supply because really, as the CDC has pointed out, there is no need to go beyond that. So we have got that.

We are also looking at prescribers. Unfortunately, while most providers are good, upstanding individuals, we do have a number of people who are overprescribers. And so, we work with our MEDIC, who is our sort of fraud integrity contractor, to really look at identifying the outliers.

They provide reports on who those outliers are. And we rely on our plans to really be able to monitor for that. And then, obviously, States use their PDMPs and other things to help them identify where they see outliers, as well. It is really a multipronged approach.

Mr. Schrader. Yeah, we have that issue in my part of the profession, also. There are a few outliers, unfortunately, that give the rest of us grief and lead to sometimes more overregulation.

I certainly appreciate your approach and CMS' approach to work with the providers to come up with that right balance to get good results, and it looks like we are getting there.

Ms. Brandt. Slow but sure. We still have a ways to go.

Mr. Schrader. I yield back, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentlelady from Tennessee, 5 minutes, for questions, please.

Mrs. Blackburn. Thank you, Mr. Chairman.

I have two questions that I wanted to talk with you about. The Medicaid Drug Improvement Act, which is going to look at the States' drug utilization review or the DUR programs and would put in place the minimum standards for the States while giving them some flexibility to determine what is and isn't going to work.

But they would have to have a minimum standard for the limitations in place for the opioid refills, monitor concurrent prescribing of opioids and other drugs, monitor the antipsychotic prescribing for children, and have at least one of the naloxone-buprenorphine combination drugs on their formulary.

And as I mentioned in my opening statement, TennCare has already put in place some of these limitations, but as we have seen the growth of Medicaid and with the Medicaid expansion, I wanted you just to talk a little bit about what you think putting these guidelines in place, passing this legislation, what that would do to help with clinical care and the health outcomes for our Medicaid enrollees.

Ms. Brandt. Thank you. It is a great question. And as you may be aware, actually in the fiscal year 2019 budget there is a proposal to establish minimum standards for Medicaid drug utilization review programs, and that is something that we think is an important first step.

We have already seen that States have been using many tools to address this. We get reports through our DUR report each year that let us know this, and States have been using a lot of medical management

techniques like step therapy, prior authorization --

Mrs. Blackburn. What are the outcomes when they report them to you?

Ms. Brandt. I think thus far, from what we have seen in some of the initial outcomes that we have gotten from our DUR reports, is that it seems to be going well, that these things are making a difference and it is starting to make an impact.

Mrs. Blackburn. How many States are doing this, electing to do this, to move forward with it?

Ms. Brandt. Well, right at the moment we have 37 States that limit the short-acting opioids, and we have 39 States that limit the quantity of long-acting opioids.

Mrs. Blackburn. So we have got different components that are being implemented in different States?

Ms. Brandt. Correct.

Mrs. Blackburn. Would it be helpful if you had the benchmarks that they had to hit across the board?

Ms. Brandt. Well, I think that is one of the reasons that the President's budget proposal advocates for minimum standards, so that there would be something unified across the board.

Mrs. Blackburn. Okay. That is great.

Let's talk about the IMD exclusion, because this comes up in nearly every provider meeting that I have, and in my district in Tennessee I have constituents who are so involved in the delivery of substance abuse and mental health programs. And so the IMD exclusion

comes up a good bit.

So if you will elaborate on your efforts there. I know that Ms. Verma is working on this issue. She has mentioned that she is. But we want to ensure that Medicaid enrollees are going to be able to get access to the needed care.

Ms. Brandt. Well, as I mentioned in my testimony, our goal is to make sure there is the right treatment in the right setting for the right individual, and a big part of that is allowing flexibilities for IMD.

So as I mentioned, since last November we have implemented some new demonstration projects in five States, Louisiana, New Jersey, Utah, Indiana, and Kentucky, all of which have flexibility to be able to waive IMD requirements and allow them to have greater residential flexibility.

We have gotten a lot of interest from other States and we are talking with them about giving similar flexibilities, and look forward to working with you all as a committee to determine how we can address this from a statutory perspective.

Mrs. Blackburn. Thank you. I yield back.

Mr. Burgess. The chair thanks the gentlelady.

The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for your questions.

Ms. Eshoo. Thank you, Mr. Chairman.

And thank you, Ms. Brandt, for your testimony and your work at CMS.

Ms. Brandt. Thank you.

Ms. Eshoo. I have several questions.

Let me start with this, and it is hard to get the exact amount. Do you know how much we spend today, what the Federal Government spends on services related to opioids?

Ms. Brandt. I do not have an exact number for you.

Ms. Eshoo. Approximate?

Ms. Brandt. I would say that it is definitely in the hundreds of millions, but I couldn't give you an exact number. I am happy to get back to you.

Ms. Eshoo. I think it would be helpful because the committee staff doesn't have it either.

Ms. Brandt. We are happy to look from our perspective.

Ms. Eshoo. But at any rate, it comes from different places, and I understand that, and there are grants and all of that.

I believe the majority of it is funded through Medicaid, though, correct?

Ms. Brandt. Medicaid is certainly a part of it. There are multiple funding streams in the Federal Government, including NIH, CDC, SAMHSA, FDA. So there are multiple components.

Ms. Eshoo. But I do think that Medicaid is the single largest payer both of mental health services and substance abuse, or a major player in it.

Ms. Brandt. It definitely is for behavioral health, yes.

Ms. Eshoo. All right.

Now, this is a little bit of a tough question, but the agency I am sure had done some kind of analysis of this. The President's fiscal year 2019 budget proposal slashes $1.4 trillion from Medicaid. So have you done an analysis of that and the impact it will have on the very issue that we have 35 bills on in this committee, on opioids?

Ms. Brandt. I think that the challenges with the opioid epidemic is it is not something that we can necessarily spend our way out of. We want to make sure that --

Ms. Eshoo. Well, that is not what I am asking you. I am not asking you that.

Ms. Brandt. We have not done an analysis, specifically.

Ms. Eshoo. Money provides access to fill in the blank. Member after Member, this is not a partisan issue, Member after Member has spoken to the needs of people in their communities, the needs for access to a variety of services, one of the most important being treatment for this after people are hooked, after they are addicted. So there is a direct correlation between dollars and services.

So maybe you haven't done an analysis, you can tell me that, but I think that it is important to put this on the table. Otherwise this is an extraordinarily serious issue that is plaguing the country, and we are going to reduce it, diminish it to next to nothing if, in fact, this $1.4 trillion is cut from Medicaid. I mean, this is reality. That is the proposal, the President's budget.

So I would like to hear back from the agency as to what your analysis is to the impact of Medicaid and the issue of opioids,

otherwise we are just fooling ourselves here.

I mean, it is important to have the discussion, but if, in fact, there is going to be a balanced budget amendment that comes up on Friday, what is contained in that? How is it going to affect this issue? There is a linkage between all of these. And I think unless and until we acknowledge that, that we are really not being straight up.

Now, I am very proud that Stanford University is in the heart of my congressional district. I think they are doing great work in the telemedicine space, specifically for opioid and pain management treatment. They have told me that there are barriers to Medicare and Medicaid reimbursing telemedicine, such as originating site requirements.

Does telemedicine, do you think, save the Federal Government money compared to in-person medicine?

Ms. Brandt. We absolutely --

Ms. Eshoo. That is such a softball question. So there is the softball.

Ms. Brandt. We appreciate the question, and it is one of the top priorities of the current CMS Administrator.

Ms. Eshoo. That is not what I asked you. I asked you if you believe --

Ms. Brandt. And she does believe it has money-saving possibilities, and it is something we are pursuing as part of our proposed payment rules for this next year.

Ms. Eshoo. Do you think the patients, whether they are in a rural

setting or an urban setting, should be able to access telemedicine if it is appropriate, obviously, for them?

Ms. Brandt. We absolutely believe it is a very critical tool, particularly for the rural areas and for underserved communities.

Ms. Eshoo. Has CMS identified any barriers that providers face when trying to use non-opioid treatments for pain?

Ms. Brandt. We have been working with the providers to discuss how we can eliminate some of the barriers for treatment and are trying to work with them on solutions.

Ms. Eshoo. Well, that is pretty broad. What steps has the agency taken to reduce the barriers?

She can answer. I won't ask anymore.

Ms. Brandt. We have had a number of stakeholder sessions, as I said, and have been engaged in lots of discussions with the industry to figure out where the barriers are and how best to address them.

Ms. Eshoo. Thank you.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Ohio, Mr. Latta, 5 minutes for your questions, please.

Mr. Latta. Thanks, Mr. Chairman, and thank you very much for holding today's hearing.

Again, the opioid epidemic is a scourge on this country. And in the State of Ohio, I am sure, Ms. Brandt, you are aware, that we are about the third hardest hit State. We had 5,232 people lose their lives

because of it by the end of the fiscal year of June 30 of last year.

But in 2015, six newborns a day were admitted to Ohio hospitals for neonatal abstinence syndrome, NAS, because of drug use by their mothers, and the cost to Medicaid is $133 million. The State of Ohio has been diligently working to address this issue and helping to improve health outcomes for the moms and the babies out there.

Could you point to any CMS efforts to prevent and treat neonatal abstinence syndrome? For example, States may also include funding for facilities that provide care for infants with NAS to an 1115 demonstration waiver. That is correct, I believe.

Ms. Brandt. Certainly. Certainly this is an issue that we know is very important not only in Ohio, but lots of other States. And we have been working to commit resources to really help mothers and their infants that are struggling with opioid addiction.

One of the ways that we have been doing it is through the Early and Periodic Screening, Diagnostic, and Testing services, or EPSDT. We are requiring States to provide a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21. This would include providing treatment services for conditions such as neonatal abstinence.

I mentioned earlier, but in February we approved a State plan amendment for West Virginia to provide additional treatment services for neonatal abstinence syndrome in NAS treatment centers. This would allow West Virginia to reimburse all medically necessary NAS services through an all-exclusive bundled cost per diem rate based on a

prospective payment methodology. And it also would allow them to fund things like nursing salaries, supportive counseling, and case management, which are important wraparound services.

Mr. Latta. Thank you.

And last week in my district I held a roundtable with pharmacists also to talk about the opioid crisis in Ohio, and most of the pharmacists agree that we need to have non-opioid alternatives for pain treatment and management; furthermore, that payments need to be expanded to alternative drugs and therapies outside of opioids.

Should CMS be taking the lead in setting the example to private payers by encouraging non-opioid alternatives for pain management.

Ms. Brandt. Absolutely. As I mentioned in my oral testimony, we are looking very aggressively at MAT and how we can provide that, including things such as naloxone, to be able to have other non-opioid treatment alternatives to be able to address the problem.

Mr. Latta. How do you get that information out to everybody out in the real world who are treating folks and saying that we need to make sure we are using non-opioids? How are you doing that? How are you getting that information out?

Ms. Brandt. We have a variety of methods that we use. We have Medicare Learning Network, MLN, which allows us to get information out. We have open door forums. We have our plan sponsors communicate directly with their providers, and we communicate directly with Medicare providers through various listserves and emails and other things.

We have also partnered with the Centers for Disease Control and other Federal partners to try and get the word out. But we can always work with you all to do more and to try and figure out how to do that more effectively.

Mr. Latta. Okay. And also there is often a lot of discussion about developing new drugs for pain treatment, but also new medical devices have also shown promise in effectively managing pain.

What has CMS done to make sure that medical devices are included in CMS' efforts to address this crisis?

Ms. Brandt. That is actually a big area. I can tell you during our stakeholder sessions and during the meetings that myself and other members of the CMS team have had we have had probably hundreds of people come in with various alternatives and other things.

And we have been working very closely with the FDA, who is our partner in this, to be able to figure out a parallel track process so that as they are approving new alternatives we can simultaneously be looking at coverage and reimbursement for them to help get those alternatives in the system as quickly as possible.

Mr. Latta. Well, thank you very much.

Mr. Chairman, I yield back the balance of my time.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from California, Mr. Cardenas, 5 minutes for questions.

Mr. Cardenas. Thank you very much, Mr. Chairman. I am glad we

have an opportunity once again to speak about this very, very important issue that is crushing our communities and individuals and families.

Ms. Brandt, what is your current title?

Ms. Brandt. Principal Deputy for Operations.

Mr. Cardenas. Okay. And do you report to somebody who is a permanent person in that position or are you reporting to somebody who is actually temporary as you go up the ladder?

Ms. Brandt. Well, I report directly to the Administrator for CMS, who is appointed by the President.

Mr. Cardenas. Okay. All right. Thank you. Many times when we have these hearings there are a lot of vacancies in and around the people who are testifying. I am glad to hear that they have a permanent person in that position.

Ms. Brandt. I am, too.

Mr. Cardenas. I want to point something out and then ask you a question. And what I want to point out is that often when we talk about healthcare we never mention how it interacts with the justice system, and when we talk about improving the justice system we leave out healthcare for children. Even if we do talk about both of them at the same time once again, with the children we tend to leave them out of the dialogue.

My bill, which is in our committee, which is being discussed today, the At-Risk Youth Medicaid Protection Act, does just that. This bipartisan bill, which I was proud to work on with Congressman Morgan Griffith of western Virginia, keeps the government from kicking at-risk

youth off of Medicaid if they come into contact with the justice system.

With this bill, when a child returns home she would immediately be able to see a doctor again and have access to any physical, mental health, and addiction treatments that she may need. Right now children are left out in the cold to battle with the bureaucracy on their own because many States are automatically kicking them off.

The opioid epidemic has grown in a way that the country was not ready for. According to a June 2017 MACPAC report, the opioid epidemic disproportionately affects Medicaid beneficiaries, and thus, State Medicaid programs are taking the lead in identifying and tailoring strategies to prevent and treat opioid use disorders.

RPTR ZAMORA

EDTR ROSEN

[4:26 p.m.]

Mr. Cardenas. It does not matter whether it is on the streets of Los Angeles or the hills of Appalachia; opioid addiction can cripple communities and destroy families. But amongst those affected the most are our most vulnerable, which is our youth.

Kids suffering from addiction need to be able to see a doctor and get better quick. In some States, when a child comes in contact with the justice system, her access to Medicare is permanently terminated.

Imagine her leaving the facility with a lot of -- without family support, wanting to get better, and trying to figure out how to continue with her recovery, manage her mental health issues though she has no ability to refill her medication, get back into school, and find housing.

On top of all that, do we really expect her to have to fill out a bunch of Federal forms and wait until she can get the support that she deserves and needs so badly? The bill that I am talking about does, in fact, fix that.

The need for continuous access to healthcare goes beyond the opioid crisis and not just benefits to children, but also their families, their communities, and the society they will continue to be successful as adults in.

This bill will ensure that children do not fall through the cracks

because of red tape that adults created. The legislation has broad support in the law enforcement, healthcare, and social justice communities. I appreciate the ability to discuss this bill and look forward to seeing it advance through the legislative process.

Ms. Brandt, currently Federal law prohibits States from receiving Federal financial participation for individuals covered by Medicaid while they are incarcerated. It does not, however, specify how each State should handle the Medicaid enrollment of these individuals once they get back in the community.

While some States are beginning to suspend instead of terminating Medicaid enrollment of incarcerated individuals, 19 States still permanently terminate healthcare coverage of incarcerated individuals.

Therefore, I ask you, do you agree that these policies limit the ability of most incarcerated children who are covered by Medicaid to access treatment for substance use disorders once they are back in their community?

Ms. Brandt. Well, I am not familiar entirely with the policies that you are describing, but as I said before, we are committed to working with States to be able to provide flexibility so that they can get the right treatment to the right people, whether that is juveniles, infants, or others.

And so, we are happy to work with you to provide technical assistance and work with the issues. I can't speak specifically beyond that, because I am not familiar, but we are committed to providing the

right treatment and the right setting to the right people.

Mr. Cardenas. Well, I am familiar with that one point that is affecting so many young people in our country. And the point here is that we can and hopefully will clarify in the law that the States do have that option right now to continue to remove them -- right now they have the option to remove them once they come in contact with the justice system.

But what should be happening, they should be suspended, because they are going to get out. And for a person with any medical need, mental or otherwise, shouldn't have to go a month, 2, 3, 4, 5, 6, without the care that has already been identified for them, and that is the rub and that is the part that we are trying to fix. So hopefully we will do that and then you will be able to follow suit.

Ms. Brandt. Very good. Happy to follow.

Mr. Cardenas. Thank you. I yield back.

Mr. Burgess. The chair thanks the gentleman.

The chair would observe we have a series of votes that have been called on the floor. We will entertain questions from Mr. Shimkus, and which we will then recess until after the vote series.

Mr. Shimkus, you are recognized for 5 minutes, please.

Mr. Shimkus. Thank you, Mr. Chairman.

So Dr. Burgess, and also, really, Dr. Schrader, mentioned the concern on the chronic pain end of these folks. And I have been trying to carry that message, because they are different, right? They are not addicted. They need it to just live normal lives.

Having said that, could you -- because I get a lot of questions on this issue of the editing process that you have. Can you briefly explain that. I know that there is a soft edit, hard edit, and that is milligram based, and what the purpose is and why we do it that way.

Ms. Brandt. Sure. So the whole purpose, again, of the edits is to make sure that if you see folks who are potentially over-utilizers, for instance, someone, as I mentioned before, who would be receiving maybe 90 morphine milligram equivalents or higher on a sustained basis for up to 6 months or more, maybe getting prescriptions from three or more providers, three or more pharmacies, people who look like they really are not someone who maybe has, you know, a dedicated physician, a dedicated care issue.

The whole point is that the pharmacist works with the provider to be able to have a discussion about whether or not that pain treatment is right for that individual. The whole point of the edits is to serve as a flag, if you will, to be able to highlight it so that if you have something that looks like an aberrancy, we can stop it early.

The 76 percent number that I keep going back to, I think, is an important example of this, because by using those types of edits, we have been able to really reduce those numbers by, you know, over 25,000 individuals, and that is a significant step forward in that program.

So the point of the edits is more to ensure that there is the right treatment being provided to the right person, and to have that discussion amongst the care team about what that is.

Mr. Shimkus. So are we seeing any response by the chronic pain

community that this is inhibiting their ability and slowing up the process of prescriptions for them?

Ms. Brandt. Well, as I said, that is something that we have had a very active dialogue with the community on. We got a lot of comments on that back in response to our call letter. And we have really been working with them to try and make sure that we are striking that right balance.

That is one of the reasons in the call letter that we went to a 7-day initial fill for acute pain, and to make it so that there was the ability to have that conversation between the pharmacist and the provider about the needs of the individual so that hopefully someone who has cancer or some other disease that requires them to need these drugs would be able to get them and to keep getting them as appropriate.

Mr. Shimkus. And Illinois is an 1115 waiver State. Can you explain some of the issues with applying for that? I think it is going to end up being a big discussion within the committee about, if it is working, then we need to make sure that that is working and why versus other responses to this issue that we may hear from some of our other colleagues.

Ms. Brandt. Well, again, the whole goal of our waiver process is to allow States more flexibility, and it is to allow them more flexibility to be able to utilize their resources to treat the opioid crisis in their State as best fits the needs of their State.

Each State is very unique and has different populations and different needs and different resource constraints, so the idea is to

be able to work with the States to give them the flexibility.

Mr. Shimkus. And how many States do we have in that process right now?

Ms. Brandt. Well, as I mentioned, since we started the new process in November, we have gotten five States that have gotten substance use disorder waivers. I can't speak to the total number because there were waivers before that, but since we sort of began the new process, there are five States that have been approved. And we have discussions ongoing with several others.

Mr. Shimkus. And I would just like to end on the -- obviously in the coding issue and reimbursement on nonopioid pain management treatments. Obviously, you have heard the concern that if we don't adequately reimburse them, it may move to pain management through a different venue by which we would end up having more challenges than we would like. Can you talk about your involvement or your concern about CMS and coding?

Ms. Brandt. Certainly. Again, that is an area where we are having an ongoing dialogue with the provider community to determine what the right levels are there in terms of coding and how we can work with them to make sure to balance, you know, the burden with the appropriate targeting of treatment and codes for that.

Mr. Shimkus. I appreciate you being here. Thank you for your time.

And, Mr. Chairman, I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman

yields back.

And once again, the chair observes we have a series of three votes on the floor of the House. The committee is going to briefly recess while we record those votes over the in the House Chamber, and we will reconvene immediately after the last vote.

I thank the witness for the forbearance during that time.

Ms. Brandt. Thank you.

Mr. Burgess. The committee stands in recess.

[Recess.]

Mr. Burgess. I call the subcommittee back to order. I want to thank everyone for their forbearance while the vote series occurred.

At this point, I would like to recognize for 5 minutes the vice chairman of the conference -- or the chairwoman of the conference, Cathy McMorris Rodgers, 5 minutes for your questions, please.

Mrs. McMorris Rodgers. Thank you, Chairman, Ms. Brandt.

I want to first applaud CMS for clarifying in the final part D rule that MTM programs will fall under quality improvement activities when calculating the medical loss ratio requirements. This should encourage plan sponsors to expand access to MTM programs, which will ensure a greater number of patients can benefit.

Given the important role pharmacists can play in addressing the opioid epidemic, we are considering legislation today to add patients at risk for prescription drug abuse to the list of eligible beneficiaries for MTM under Medicare Part D. Can you please give us your thoughts on utilizing pharmacists to help address the opioid

epidemic?

Ms. Brandt. Thank you.

We think that pharmacists are a very important part of the care coordination. As I mentioned in several of my answers today, pharmacists play a vital role and are on the frontline in helping work with providers to address this. And we think the MTM treatments, in particular, have been very beneficial to beneficiaries, and we look forward to working with you to expand that.

Mrs. McMorris Rodgers. And while we are on the topic of MTM, can you provide us with a quick update on where CMS is ensuring sufficient retail pharmacy representation in the CMMI enhanced MTM model demonstration project?

Ms. Brandt. I can't speak specifically to that, but I am happy to get back to you with some more information about how that is going. I am sorry. I am just not familiar with that particular one.

Mrs. McMorris Rodgers. Okay. That would be great.

I am interested in how existing dollars can be leveraged in the effort to help educate providers providing care for patients with substance abuse disorder. When we spend more than $2 billion in Medicaid-funded GME programs each year, it is just common sense for Congress to better understand how these programs are helping to train providers on pain management and substance use disorder.

For example, the University of South Carolina implemented a program into their medical school curriculum to address the opioid crisis using case studies, panel discussions, and group work.

By the end of medical school, all USC-trained medical students will be able to recognize patients that are at risk for substance abuse, and have solutions for treatment. I think that this is a great model for other medical schools.

Do you think that it is appropriate use of GME dollars, particularly since Medicaid beneficiaries represent a disproportionately large share of those with substance abuse disorder?

Ms. Brandt. Well, we certainly agree that education is an important component. And we agree that, you know, we want to continue, as we have been doing, to work with States in the accrediting organizations to make sure that GME dollars are put towards education to help make sure that that is targeted in the appropriate way.

Mrs. McMorris Rodgers. Thank you.

I would also like to take this opportunity to submit for the record from the Washington State Pharmacy Association, pharmacists play a unique role in patient care and are frequently the healthcare professional that a patient sees the most, especially in our rural communities.

Authorizing pharmacists clinical services under Medicare Part B, which H.R. 529 accomplishes, will go a long way to empower pharmacists and give them an opportunity to help address prescription drug misuse and abuse.

So I would like to submit this letter for the record, Mr. Chairman, and with that, I will yield back.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yields back.

The chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for your questions, please.

Mr. Kennedy. Thank you, Mr. Chairman. I appreciate the opportunity to have this hearing.

Thank you, Ms. Brandt, for being here as well, answering our questions.

Mr. Chairman, I would like to start just by submitting or requesting an opportunity to submit for the record a letter of support from about 2 dozen or so organizations in support of our mental health parity bill, if you would be so kind.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Kennedy. Thank you, sir.

Ms. Brandt, I wanted to drill down a little bit your understanding and the administration's understanding about the current status of Medicaid with regard to the two areas of focus, substance abuse and mental illness, with regards to some of the policies that I think have been put forth from a couple of States that you mentioned earlier.

Do you have any information or data that indicates how long it takes the average patient to recover from a substance use disorder?

Ms. Brandt. I don't know exactly the amount of time, but I can get back to you with any information that we have.

Mr. Kennedy. Yeah. And I would imagine that it obviously is going to vary quite a bit individual to individual.

Ms. Brandt. Yeah. I think it depends on the type of person, the type of treatment, and the setting.

Mr. Kennedy. Yeah. And I would assume, with regards to a broader mental health issue, some of that is, obviously, a lifelong condition and some of that with adequate treatment and access to care can be successfully managed. Is that fair?

Ms. Brandt. That is fair, yes.

Mr. Kennedy. So you can imagine my concern, Ms. Brandt, when I hear that five States, Maine, Arizona, Utah, Wisconsin, and Kansas, have applied for waivers to impose lifetime limits on Medicaid patients in their States, knowing that substance use orders and mental health problems are often lifetime challenges, and knowing that Medicaid is a single largest payer of behavioral health service in this country.

How do I understand the testimony that you have given so far, and this administration's stated commitment to provide access to care, particularly in the midst of an opioid epidemic, recognizing that for the young people that are afflicted with this epidemic, it is going to be a lifelong issue and a lifelong challenge with a policy of lifetime caps? How do I rectify that?

Ms. Brandt. Well, as I mentioned before, we have been working to try and work with States to try and give them as much flexibility as they can to manage the populations in their area to hopefully get the right treatment in the right setting for the right duration.

Mr. Kennedy. And so how -- but under what -- under that circumstance -- and I appreciate your answer, but how is a lifetime limit ever going to be the appropriate response for somebody facing a lifetime illness?

Ms. Brandt. Well, I can't speak to that specifically, but, again, we are committed to working to give the States the flexibility they need to hopefully provide the right types of treatments for their individual constituents.

Mr. Kennedy. So with regards to a similar policy and a work requirement, is there a study that you are aware of that indicates that Medicaid -- that people are healthier, not the causation between health and work, but between work and health? Are you aware of a study that shows that if you are -- that work will make somebody healthier?

Ms. Brandt. I cannot speak to such a study.

Mr. Kennedy. I can't either. I am not sure there actually is

one. And so I am curious as the administration tries to push forward with a Medicaid work requirement, you had said earlier that the philosophy of this administrator was that patients -- was to put patients over paperwork.

I think we can agree that when it comes to a work requirement, the paperwork necessary for an individual patient to try to either, one, prove that they are working is an additional administrative burden; and two, to try to provide, assuming that you are carving out some sort of exemption for people under certain conditions, mental illness, caregiver, student, others, that that is an additional administrative hurdle on top of that. How is that putting patients above paperwork?

Ms. Brandt. Well, with the States where we have already gone ahead and worked with them, one of the things that we tried to do was to make sure that we -- the States would make reasonable modifications.

And we are trying to work with them to ensure that they are striking that appropriate balance, to ensure that they are getting people access to the treatment they need without hopefully having additional bureaucratic requirements.

Mr. Kennedy. And if somebody is suffering with a mental illness, such that they -- as I know over the course of -- you have been dedicated to public health and health policy for a long time, the challenges that those individuals and families have with getting access to care and maintaining the care that they need, and the struggles that they go on on a daily basis to sometimes get through the day, the administrative

burden added for them to prove that they are -- should be exempt for those work requirements, does that not make it even harder for them to do so? And if so, isn't the risk of them losing access to their healthcare and Medicaid even higher to one of the most at-risks populations we have got?

Ms. Brandt. Well, to your point, that is one of the reasons that we remain committed to trying to work with States to sort of strike that reasonable balance I talked about. We want to make sure people have reasonable access and the appropriate access to the care they need in those States, and, hopefully, balance that with the requirements needed to be able to show that they need that care.

Mr. Kennedy. And how would a work requirement ever tilt in the way of a patient for access to health?

Ms. Brandt. As I said, we are working with States to try and make sure to assure that balance.

Mr. Kennedy. Appreciate that. Thank you.

Yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for your questions.

Mr. Griffith. Thank you, Mr. Chairman.

Appreciate you being here this afternoon.

The Medicaid Pharmacy Home Act that the committee is considering would require that States take into account a patient's history of

receiving care in geographic proximity to providers and pharmacies when locking a patient into two providers and two pharmacies. How would CMS define proximity?

Ms. Brandt. Well, that is a good question and something that in each of our rulemaking, we actually look to do. We recognize that we are always looking to make sure that we can ensure appropriate access for patients.

As I said, we want to make sure people are getting the right treatment in the right setting, and so it is something that we are definitely always looking to determine what is the right proximity. Is it driving distance? Is it actual mileage distance? What is the appropriate balance? And that is something that we do through notice-and-comment rulemaking and working with individuals such as yourself.

Mr. Griffith. And you anticipated the next part of my question, because I was going to go to, historically it has been a mileage requirement, but in districts like mine, which have mountains in them, you know, one town might be closer as the crow flies, but not nearly as close on driving time.

So that -- you know, I have got a classic situation in one of my areas where in Dickenson County, Haysi, and Clintwood, on the map may look like they are 15 miles apart but there is a mountain in between.

And because of the road that goes around the mountain, I have been advised by the mayor of Haysi that he allots -- it doesn't always take him that long, but he allots an hour to get from one down to the other.

When he has a meeting over in Clintwood, he has to allocate an hour on his calendar, weather, coal trucks, timber trucks, a slow driver worried about the curves, all can make that trip a lot longer, and there may be closer facilities that the drive time is better for, or whatever, and keeping that in mind. And I just ask that as you all look at this -- and we will too -- if you would keep that in mind, I would greatly appreciate it.

Ms. Brandt. We certainly will.

Mr. Griffith. Thank you.

In MACPAC's report this past June, the commission noted research in health affairs that found States with prescription drug monitoring programs requirements saw reduction in opioids prescribed to Medicaid enrollees, reducing the total scripts in the dosage as well, and a reduction in Medicaid spending on those prescriptions. A 2016 CMS bulletin also highlighted similar findings.

Wouldn't you agree that this evidence demonstrates the critical role of the PDMPs in addressing the opioid epidemic, saving both lives and dollars?

Ms. Brandt. Yes. We absolutely think the PDMPs play an important role. Forty-nine States currently have a PDMP, and we are very much committed to continuing to work with them to ensure that they are as effective as possible.

For instance, the State of New York, which has been requiring prescribers to access a PDMP, has seen a 75 percent drop since 2013 and the number of patients who use multiple prescribers and pharmacies

for controlled prescription drugs just because of the PDMP.

Mr. Griffith. And appreciate that.

The Medicaid Partnership Act draft before us allows States flexibility in how they design their programs. However, it also ensures that PDMPs are a part of Medicaid's provider clinical flow work. If more physicians and pharmacists were checking the PDMP, would you expect the number of opioid prescriptions to decrease? I would.

Ms. Brandt. Well, as stated with the example I just gave you from New York, we think that there is a lot of promise to having greater access to PDMPs, and to making sure that people are utilizing them.

Mr. Griffith. Now, here is an interesting twist that we have to try to figure out. If you have the prescribers checking it, is it duplicative to have the pharmacy checking it also?

Ms. Brandt. Well, it is a good question. And, as I mentioned before, we view the pharmacist as well as the prescriber as part of that care coordination team. So it is something where prescribers have been checking this, but we also view the pharmacist as a part of the discussion, and it is something we are certainly open to discussing with you all.

Mr. Griffith. Yeah. I think we do need to discuss it, because one of the things that it also says is is that if there is a patient in hospice or palliative care, they would be exempt from the requirement to consult the PDMP. How is a pharmacist going to know that? The prescriber should know that, but --

Ms. Brandt. It would be -- at this point in time, I do not believe

that type of information would be available to people checking the PDMP, so that would be an impediment.

Mr. Griffith. Right. So we have got to figure that out if we are going to go forward on that particular line of the bill. But I do think we are all trying to work in the same direction, and I appreciate any input that you can give us to make our bill, as we go forward and discuss it, better and practical.

Ms. Brandt. Well, we look forward to offering technical assistance, and this is an area that we have been very focused on, so thank you.

Mr. Griffith. Thank you, and I yield back.

Mr. Burgess. The chair thanks the gentleman.

The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for your questions, please.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it.

I appreciate your testimony as well.

Ms. Brandt. Thank you.

Mr. Bilirakis. Thanks for your patience.

Ms. Brandt. No problem. It has been a long day for everyone.

Mr. Bilirakis. Yeah. Not over yet.

Last week, CMS issued final rules for Medicare Part C and D, which include the rules for the lock-in program. This program is important for me not only because I authored the provision, but also because addiction is a serious problem that cuts across age, gender, and income.

Programs like Medicare need to have and use all the tools

available to help beneficiaries. Let's see, can you update the committee on what changes CMS did with this implementation of the drug management program for at-risk beneficiaries, also known as lock-in, in Medicare's Part D program, please.

Ms. Brandt. Certainly. As I mentioned in my oral testimony, we were very appreciative of the additional tool that Congress gave us. This is a very important tool in our fight at the Federal level against the opioid epidemic.

Starting next year, plan sponsors have the option to go ahead and implement a lock-in requirement, which would require a beneficiary to use certain providers and/or certain pharmacies, depending on, you know, what is deemed appropriate.

There is also a proposal in the President's budget to do mandatory lock-in for plans. Again, ours is a "may" not a "shall" right at the moment, but the President's budget has a "shall." But we think that the lock-in authority is something that will be very helpful.

We have seen a lot of good results from States. Many of the States have been using lock-in authority. And we think that some of the early results from States we have seen, such as Pennsylvania, which has saved about $55 million in 2016 from using lock-in authority, are a good indicator of where we can go with this authority going forward.

Mr. Bilirakis. The President's budget has a "shall," recommends a "shall" --

Ms. Brandt. Right.

Mr. Bilirakis. -- as opposed to the "may"?

Ms. Brandt. Correct.

Mr. Bilirakis. And my original bill had a "shall" as opposed to the "may." Why do you think it is so important to -- if that is your position as well, because I agree it should be a "shall." Why do you think it is so important that we say "shall," and require them to have the lock-in program under Medicare as opposed to giving them a choice?

Ms. Brandt. Again, it is a very -- it is an important extra tool for our toolbox. And without -- you know, if the tool is optional, it doesn't mean it can always be used. But if the tool is mandatory, that means it can and should be used.

And it is just another important tool to allow us to address those really high over-utilizers and to be able to take important steps to limit their usage and to be able to protect the program.

Mr. Bilirakis. And, again, we want to emphasize this is only for high risk?

Ms. Brandt. Only for high risk. Only for those who are particularly high risk. And as I indicated from the results we saw from the State of Pennsylvania, we think they will also have cost implications to the programs in terms of savings, which is something that we are always looking for, particularly in the Medicare side of the house.

Mr. Bilirakis. Very good. Thank you. Under Medicare, yeah. Thank you.

Next question. Do I have time? Yeah, I think I am all right. Almost every State Medicaid program runs or authorizes a lock-in

program using, physicians or pharmacies, or a combination of both. Every State Medicaid program runs their program differently from each other.

Does CMS currently collect data from States on their Medicaid lock-in programs, such as how it is structured, eligibility triggers, estimated cost savings, outcome measures, or other data that could help States with establishing best practices?

Ms. Brandt. So we are starting to do that through our Medicaid drug utilization review program. Our DUR reports that we get are allowing us to start to get that sort of information.

It is still -- we are still sort of, I would say, solidifying exactly what requirements we are getting, but it does allow us to get a snapshot of what is working. And that is how I was able to give you an example from Pennsylvania, you know, where we were able to see some initial positive results from their lock-in program. So it is something that we are starting to collect.

Mr. Bilirakis. How many States actually collect this data?

Ms. Brandt. I would have to get back to you with that. I don't know the exact number of States.

Mr. Bilirakis. But there are advantages for the States to collect this data?

Ms. Brandt. Absolutely. Because as you can tell, you can provide savings data. It also provides data on how it reduces over utilization and other important markers that we can use from a program management perspective.

Mr. Bilirakis. Okay. Very good. Thank you.

I yield back, Mr. Chairman. Appreciate it.

Mr. Burgess. The chair thanks the gentleman.

The gentleman yields back.

The chair recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for your questions, please.

Mr. Bucshon. Thank you, Mr. Chairman.

I was a surgeon before, and I was in healthcare. I have seen this problem coming for 25 years, caught up to us pretty quickly for a variety of reasons. There is no one particularly at fault, but I think we kind of got caught with that.

And, you know, it is going to take us a while to get out of this problem. It is a multifactorial in origin as well as the solutions to it, all the way from border security and preventing the 90 percent of heroin that comes to the United States from coming across our southern border, all the way to the other end of the spectrum where we have to provide affordable treatment options for people who are currently addicted.

I have seen, you know, countless families in my district, in the 8th District of Indiana, destroyed due to this. We are losing a lot of people in all of my counties. Rural America is devastated by this problem.

And I believe that some more emphasis maybe should be placed on innovative treatments, including medications and devices, to help individuals manage pain without becoming dependent on opioids.

And CMS plays a critical role in this effort. That is why I have worked with Scott Peters, who is down at the end, on the Postoperative Opioid Prevention Act to create a temporary pass-through payment to encourage development of nonopioid drugs for post-surgical pain management and Medicare.

Additionally, I am working on a draft legislation to add an evaluation of management of chronic pain to the Medicare initial assessment, which would include an emphasis on nonopioid pain management alternatives. Have you had a chance to look at those options?

Ms. Brandt. I have not personally, but I know that our office has been reviewing them for technical assistance.

Mr. Bucshon. Okay. It is important to remove barriers to access for patients new options for management of post-surgical and chronic pain in order for society to shift from the overreliance on opioids.

My daughter, for example, went to -- and had her wisdom teeth taken out, and her dentist wrote a prescription for 60 opioids. Of course, my wife and I are doctors. We never filled it. We said, you know, some ice on the cheeks and a little bit of Advil and Tylenol. But you see the extent of this problem.

We still, even as a provider, I will say that, you know, providers are part of the solution, and I think we are doing much better, but we have a ways to go. It is a cultural shift that we need. It is, you know, starting in training, I think, all the way up through current practitioners, and I think that we are going to get there.

I know there is barriers to nonpharmaceutical therapies for chronic pain. You mentioned -- I think someone asked you earlier about that. How can those barriers be addressed and primarily its coverage decisions from CMS, honestly, to increase the utilization of evidence-based therapies, particularly FDA-approved medical devices for pain?

Ms. Brandt. So as I mentioned earlier, we are constantly looking at CMS to determine how we can look at evidence-based criteria to improve our coverage decisions. One of the things we really would like to do and are trying to do is, within our statutory authority, to expand the amount of nonopioid alternative treatments that we can cover as much as possible.

And we are committed to working with the FDA and our other partners to really try and expand our reach of that as much as possible. We have been working very much with NIH to get more clinical evidence to support our coverage decisions and are continuing to try and fast track all of that to open up as many new options as we can.

Mr. Bucshon. And administrator Verma met with the Doctors Caucus this morning, and we talked a little bit about that. And I know that that is a goal to try to -- within -- and you may need some more authority legislatively, I think, to adapt, because we need to be more nimble here, you know. If we have something that is FDA approved, we need to get coverage decisions in a more nimble way, not reinvent the wheel.

And I have found, since I have been in Congress -- this is my 8th

year -- that coverage decisions are a barrier to access more than, I think, I really realized. And it is nobody's fault; it is just the way it is.

Some of the bills before us today will increase access to methadone also. An informational bulletin on best practices for addressing prescription opioid overdoses, misuse, and addiction in Medicaid was issued by your predecessors in the Obama administration. That bulletin cautioned that methadone, in particular, accounts for a disproportionate share for opioid-related overdoses and death. Methadone, as everyone knows, is an opioid.

The bulletin also warned of an increased risk of morbidity, mortality associated with methadone in the Medicaid population. Mr. Chairman, I ask for unanimous consent to submit that CMS report for the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Bucshon. I know every member here wants the patients to get the care they need, but we also need to make sure it is the right treatment from the right provider at the right time.

Can you talk about CMS's current work -- briefly, because I am almost out of time -- to better understand the clinical risks the literature associates with methadone?

Ms. Brandt. Certainly. Again, we have been looking at different ways that methadone can be utilized where it is appropriate, both for opioid use disorder and how it is currently being utilized for acute pain, in determining whether or not there are alternative treatments or other ways that we can work with you-all in Congress to expand our statutory ability to be able to use methadone where appropriate for OUD.

Mr. Bucshon. Okay. Thank you.

Mr. Chairman, I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

The chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions, please.

Mr. Lance. Thank you very much.

And good afternoon to you all.

In a CMS report on the Medicaid Health Home State Plan option, CMS noted States report that they plan to continue the Health Home Programs after the current law 8-quarter enhanced Federal match ends -- and I think it is a 90 percent match -- in part, because they

are saving money.

CMS explained States believe that the cost savings are a result of the improved health status and reduced utilization, which are expected to, at a minimum, cover the costs of the Health Home Program and anticipate savings in excess of health home costs.

Mr. Chairman, I ask that the report be submitted for the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Lance. Thank you.

Given these findings, what impact would an additional year of enhanced Federal matching for Health Homes have for States? Do you think more States would adopt this special model to provide care coordination and wraparound services for patients with substance abuse disorders?

Ms. Brandt. We have seen good initial results from the Health Home, particularly in Vermont, with the hub-and-spoke model that we have there. The Health Home has seemed to be very positive and had very good results.

So it is something that we are supportive of because the Health Homes do provide us with another option to provide the right care in the right setting, and Health Home can be an important part of that.

Mr. Lance. I would imagine that funding is safe if patients are permitted to stay in their homes. I think that that probably is a cost saver.

Ms. Brandt. I can't speak to that specifically, because I haven't seen numbers to support that. But like I said, at least initially, based on the Vermont model, it does seem that they have achieved some savings using the Health Home model.

Mr. Lance. I thank you very much.

And, Mr. Chairman, I yield back 3 minutes.

Mr. Burgess. The chair thanks the gentleman.

The chair recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for your questions, please.

Mrs. Brooks. Thank you, Mr. Chairman.

And thank you for being here and for your work.

One of the reasons why I think the epidemic, the opioid epidemic has become so pervasive is because of the prevalence of pain, and pain being the most common reason Americans access the healthcare system to begin with, and number one cause of disability in the country. We know pain is a major contributor to healthcare costs, not to mention societal costs and the economic loss because of the opioid crisis.

But how can HHS and CMS ensure that educators, or providers rather, are better educated about pain management alternatives, including the technological alternatives to opioids that Dr. Bucshon was just talking about?

How are you ensuring -- in a previous answer, I know you mentioned the Medicare Learning Network. I would like to know a little bit more about how you are doing more of the education for providers?

Ms. Brandt. Ma'am, it is a great question. I think, you know, the pain issue is one that we have really tried to address through multiple fronts at CMS. Part of it is having more of a discussion with providers about pain.

Our quality measures used to have pain management survey questions in them. We have changed those to have it be more of a discussion about pain instead of how can we just manage your pain. It is having a discussion about the type of pain and sort of why that is happening and trying to figure out the right solution.

We have also been working on quality reporting on adverse events

in the hospital to sort of work with physicians to say, okay, how can we have a better understanding of this? How do you know what the alternatives are?

So part of that is through the outreach we do through our quality improvement organizations, our QIOs, and our quality improvement network. They do a lot of outreach in physician and hospital education.

We use the Medicare Learning Network, MLN, that I talked about before, where we issue a lot of bulletins electronically that go to physicians and hospitals to update them on, Hey, here is a new treatment that you might not be aware of, or, Here is some new developments that we have on coverage for alternative treatments.

We have also tried very much to have more of an ongoing dialogue through open-door forums and just more sort of one-on-one educational interactions with various medical societies and others, to really educate them about what we are doing, and to hear from them about how we can do better.

So I think there is always more that we can do, but we have really been trying to do it through both an in-person and virtual approach, and think we can do more.

Mrs. Brooks. Has the agency kept track of -- how do you know about the utilization of that type of information?

Ms. Brandt. Well, that is the challenge. You know, we have a good idea of how many people subscribe, for instance, to our Medlearn Matters articles. We have a good idea of how many people participate

in our open-door forums and things like that.

But a lot of that information then gets disseminated on even further from there, so it is hard for us to completely track. But we are trying to do a better job of targeting our outreach.

And one of the things that our stakeholder sessions taught us was that we really are thinking through how we can better partner with our Federal partners and our private sector partners, the plans, a lot of the associations and others, to do more coordinated outreach and education in this space, and that is something we are currently working on.

Mrs. Brooks. Are you a part of -- when we passed in CARA, the interagency group that was formed with various Federal partners to focus on prescribing practices? Are you familiar with that group?

Ms. Brandt. I know that we have participation in many types of groups like that. I am not sure if it is the one specifically described in CARA. I can get back to you. But we are in active coordination and discussions with CDC, NIH, SAMHSA-HRSA, all of the different components within HHS, DEA, and others to kind of work and sort of figure out how our piece as a payer impacts with the different pieces that they have from the other perspectives.

Mrs. Brooks. I would be interested in you getting back to us as to whether or not --

Ms. Brandt. We will certainly follow up.

Mrs. Brooks. -- this was part of CARA. And I would like to know, and I think it would be important for you to participate.

I would -- would you agree, however, that we could continue to do even more prescriber education? And I am working on a bill to require more prescriber education, but to allow it to be focused at the State level, and to have the societies and the other entities at the State level oversee that type of training, because not all States require continuing medical education. Were you aware of that?

Ms. Brandt. I did not know that.

Mrs. Brooks. So that is something that not all States currently have, and so right now, it is all voluntary. Everything is voluntary, is it not?

Ms. Brandt. Yes.

Mrs. Brooks. Unless the State is requiring it. Some States do. Indiana happens to now require it.

Ms. Brandt. Right.

Mrs. Brooks. Thank you.

I yield back.

Ms. Brandt. Thank you.

Mr. Burgess. The chair thanks the gentlelady.

The gentlelady yields back.

The chair recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for your questions, please.

Mr. Carter. Thank you, Mr. Chairman.

Thank you, Ms. Brandt, for being here. Appreciate it very much.

I want to talk to you, first of all, about abuse deterrent formulations. You know, to be quite honest with you, in my years of

practice in pharmacy, when this first came out, I wasn't too high on it.

But now that we have developed as much of a problem as we have with the opioids and drugs of abuse, I am beginning to warm up to it quickly. And I see the usefulness of it and the fact that you won't be able to crush it so that you can't snort it or turn it into an injection.

So I am just wondering -- I understand that, you know, there might be some cost involved, some extra cost involved. I am wondering what kind of barriers that your agency is seeing in using these medications, and what is limiting the use to access to these types of medications?

Ms. Brandt. So right at the moment, we agree that abuse deterrent opioids are definitely a potential tool in tackling this epidemic. At this point, the epidemic is so pervasive that we are looking at any and all tools.

Mr. Carter. Exactly. I would agree with that.

Ms. Brandt. We need to explore all. I think under our current statute, we cannot tell our plan sponsors what to negotiate and what types of drugs that they have to cover on their formularies. It is the plan sponsors' responsibility to do negotiations and negotiate with drug manufacturers and determine which of the FDA-approved medications to make available to the --

Mr. Carter. Now, who sets forth those results and regulations? Is that in the statute?

Ms. Brandt. It is under current statute, yes, sir.

Mr. Carter. So that is something we in Congress can help you with?

Ms. Brandt. You have the ability to influence that, yes.

Mr. Carter. Okay. Well, that was my next question, how can we help you? And you just answered it. We can help you by rewriting those rules and regulations to include this.

Ms. Brandt. It would -- as I said, right at the moment, we cannot interfere in those negotiations under the statute as it is currently written. If you all were to change that, that could potentially give us more flexibility.

Mr. Carter. Right. Well, you know, as we -- as this evolves and as it continues, you know, it is certainly something we need to be looking at from a perspective here.

I want to go now to the Medicaid Pharmacy Home Act. And before I ask you just a couple of questions about it, I want to compliment my colleague, Mr. Bilirakis, in his work on this. I think this is good.

I have been involved during my time of practicing pharmacy with lock-ins, and I see the advantage of them, but I also see some concerns. I do think that they can help lower the incidents of fraud and abuse.

But at the same time, I am just wondering in the legislation -- you know, pharmacy preference is very important. And I have often wondered when these programs are used how they determine which pharmacy is going to be the lock-in pharmacy.

What do you think about pharmacy preference and about the patient having the ability to request a certain pharmacy?

Ms. Brandt. Well, I think, you know, as I said, we currently have this as an optional authority, starting in 2019, for our plan sponsors to do lock-in. And part of it is working with the beneficiary to make sure that it is a pharmacy that fits for them, that is geographically appropriate, that is somewhere that they can access.

And part of that is the right care and the right setting that I was talking about before. So I think that our expectation is that pharmacies and plans will work with the patients and the providers to make that best fit.

Mr. Carter. Well, you know, one of my concerns is access to the medication. I have seen situations where they are locked in to a pharmacy. That is the only place they can get it, and that pharmacy might not have a certain product that they need, and, therefore, the access is denied.

What do you think about having more than one pharmacy in that situation?

Ms. Brandt. Well, that is one of the reasons where we gave some flexibility to be able to potentially have, in certain instances, pharmacies or providers and, again, trying to do so in a limited way to sort of limit the potential for abuse, but yet, still be able to give those options that you are talking about.

Mr. Carter. Well, I am glad to hear you say that, because I think that is going to be extremely important. You know, I know that the lock-in provisions can work, but I am very concerned about -- as I say, about accessibility and particularly about patient preference. That

is very important.

And certainly, in this situation, I think it would be most important in working with the patient to make sure that they are getting the pharmacy preference of their choice would be paramount, I think, in this situation.

Well, thank you for what you are doing. Appreciate you being here today.

Mr. Chairman, I yield back.

Ms. Brandt. Thank you.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman.

All members of the subcommittee having had an opportunity to ask questions with the exception of the chairman, the chairman will now recognize the gentleman from the full committee, Mr. Tonko of New York, 5 minutes for your questions.

Mr. Tonko. Thank you, Mr. Chair. Thank you for letting me waive onto the subcommittee.

Before I begin, Mr. Chair, I have a unanimous consent request. I have here letters of support for the Medicaid Reentry Act from National Association of Counties, the American Medical Association, the American Society of Addiction Medicine, the American Psychiatric Association, Community Resources for Justice, the International Community Corrections Association, the National Commission on Correctional Healthcare, and the Coalition to Stop Opioid Overdose.

I would ask unanimous consent, Mr. Chair, that these letters be

entered into the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Tonko. Thank you, Mr. Chair, for holding this important hearing and for including legislation that I have authored, the Medicaid Reentry Act, as a part of this conversation.

And welcome, Ms. Brandt.

My goal with the Medicaid Reentry Act is simple: To reduce overdose deaths among individuals leaving jail or prison and returning to the community. We have heard from earlier hearings in this committee that this is a uniquely vulnerable population with the risk of overdose reaching as high as 129 times that of the general population during the first 2 weeks of post release.

To reiterate, 129 times more likely to die of an overdose during the period in time when an individual is supposed to be getting a second chance at life. That number is astounding and should serve as a moral call to action for our Nation.

The good news is that we are not helpless when it comes to solutions. We just need to have the will to see them through. Expanding quality addiction treatment to individuals while incarcerated can dramatically improve health outcomes and reduce overdose deaths and recidivism.

Early reviews of a groundbreaking program in Rhode Island that provides access to all forms of medication-assisted treatment in jails and prisons resulted in a 61 percent decline in overdose deaths post release.

However, widespread implementation of programs like this still face a number of obstacles, not least of which is funding. That is

where my legislation enters in, as it would grant States new flexibility to draw Federal Medicaid funds for services provided to existing incarcerated Medicaid beneficiaries in the 30-day period prior to release.

It is just common sense to initiate treatment for incarcerated individuals who are about to be released while they are in a stable, controlled setting rather than the moment they are thrown back out into the often chaotic environment to which they will be returning.

I would like to get some feedback from CMS on ways that the agency can utilize Medicaid as a tool to help this vulnerable population. And so, Ms. Brandt, given this administration's openness to providing States with structured waiver guidance when it comes to outdated payment restrictions in Medicaid when these policies stand in the way of providing beneficiaries quality addiction treatment such as the IMD waiver guidance, I am wondering if CMS has contemplated, or would be open to, promoting limited waiver opportunities around the inmate payment restriction that would similarly promote the agency's goal of reducing overdose deaths and improving care coordination for beneficiaries?

Ms. Brandt. Well, this is an issue actually that we have heard from several stakeholders about. And we have had some very extended conversations internally, and I think we are very much willing to work with you and this committee to look at what the options are, because we understand that this is a big issue. It is one that several States have come to us about, and we would be very much willing to talk with

you all about where we could potentially have some flexibilities.

Mr. Tonko. That is wonderful. It is just encouraging that the agency would commit to working with me and other interested stakeholders to explore the possibilities of developing 1115 waiver guidance around the inmate payment restriction issue, so I appreciate that.

One other obstacle that Medicaid beneficiaries leaving correction settings face is that many States terminate rather than suspend Medicaid coverage for incarcerated individuals. When States terminate benefits, this can lead to a lengthy reapplication process and gaps in care at a time when these beneficiaries are most vulnerable.

How can CMS take a leadership role in encouraging States to suspend rather than terminate Medicaid benefits for incarcerated individuals which public health advocates overwhelmingly agree is a best practice?

Ms. Brandt. That is another issue that has come to our attention and that we have been talking about how we can work with States to perhaps share best practices or better guidance, and look forward to continuing to work with you and the committee on possible solutions.

Mr. Tonko. Well, you know, whatever we can come up with. I am open to suggestions that your agency can offer us in terms of speaking to the needs of the incarcerated population. The stats are very much a guiding tool.

And we need to develop policy, I believe, that will substantiate the effective use of taxpayer dollars and not have recidivism be part

of it, and in a bolder sense, save lives.

So I thank you very much for your kind attention and look forward to working with the agency, with you, in particular.

And, Mr. Chair, I yield back.

Ms. Brandt. Thank you.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

I am going to recognize myself for questions.

And, Mr. Tonko, I will just point out the -- that is an issue that has been worked on in the past, in particular, with individuals who have been charged but then released so they were not actually found guilty.

And they fall into that conundrum that you describe, and they have to go through the reapplication process. And that is really not an agency problem; that is a legislative problem at some point in the distant past governed by offset, and that was an offset that produced a pay-for for some other policy that we thought -- that some other Congress thought was important. But I agree with you, that needs to be remedied, and I have heard from people as well.

Mr. Tonko. All right. Well, I thank you, and I look forward to working with you also, Mr. Chair.

Mr. Burgess. Let me just ask you -- and, Ms. Brandt, I also want to just address the Bilirakis bill on the lock-in. Many, many, many years ago when I was a resident in training an attending physician pointed out to us that one of the highest risk situations in medicine

was when two doctors were writing insulin orders or more than one doctor was writing insulin orders.

He said, in fact, the only thing more dangerous than two doctors writing insulin orders is two doctors writing pain med orders. Any way you stop and think about it, in the continuity of care and do people communicate with each other, and you can very quickly get into a high-risk situation.

So I think the lock-in provision is -- and some people see that as a restriction of access, but actually, I see that as continuity of care and actually good patient care. And I hope we get a chance to work on that when we do our formal markup.

Mr. Bucshon talked about the methadone program. When I was in medical school in the 1970s, I actually spent a month in a methadone clinic. I don't think it has changed a lot since the 1970s.

Ms. Brandt. Probably not.

Mr. Burgess. And it was hard on people to -- I mean, you have to go every day. You have to sign in. You have to wait your turn. You have to take your stuff. People have to see you take your stuff. It becomes very, very hard to maintain outside employment because you are spending so much time dealing with the methadone maintenance. I don't know if there is a way to change that, but I think Dr. Bucshon is onto something. We do need to think about how we are administering that.

We have a GME transparency bill, one that I have been interested in. There was a GAO report that said graduate medical education in

2015, State agencies -- State and Federal Medicaid agencies spent over $16 billion for graduate medical education making Medicaid the second largest payer of graduate medical education.

But they also pointed out a lack of transparency. I mean, do you agree that it is important to know how those dollars are being spent and where they are being spent?

RPTR TELL

EDTR ROSEN

[5:55 p.m.]

Ms. Brandt. Absolutely. Transparency on spending of that is very important.

Mr. Burgess. So you would be in agreement that better transparency going forward with our Medicaid GME dollars makes sense?

Ms. Brandt. All Federal dollars need to be accounted for.

Mr. Burgess. Thank you for that. I certainly agree.

Now, I mentioned in my opening statement, and I think we heard from Mr. Shimkus on the protecting legitimate access to patients who are on -- not just cancer patients but people who have chronic pain conditions and are maintained on an opiate and it works well, and, in fact, they are able to maintain outside employment and family relationships. So while they may be habituated they are not addicted, they don't exhibit addictive behavior, unless, of course, their chain of therapy is broken. So the forced attenuation of therapy or the rapid attenuation of therapy is something that many outside groups are concerned about. I am concerned about that because I think we will drive some of these individuals from their structured maintenance on an opiate for their chronic pain, and they will look for other avenues, and as we all know, those other avenues are heroin and fentanyl, and they are not safe because of the quality control that the criminal element does not participate in, and that is where our deaths come from.

So I do want us to be -- I want us to be careful about the prescriptions going out, and I think your overuse of work that you are doing is extremely important, and I want to be supportive of that, but I think we also have to recognize there are people where, again, we can't tighten that bolt down any more without breaking it off, and that would be a bad thing.

Ms. Brandt. No, absolutely. We absolutely concur.

Mr. Burgess. Just on the issue of the overuse or overutilization, and I appreciate that you are focusing on providers, I appreciate you are focusing on patients, but I have got to tell you, one of the things that has been frustrating for me, the CMS has a lot of data at your disposal, and we have come up against problems where pharmacies in relatively small communities have received way too much product for the patient populations they are treating, and I hope you will use when you talk about overutilization, yes, focus on the doctors who are outliers, focus on the patients who are overconsumers, but really, those fact manufacturers who to whom you are then writing reimbursements, that needs to be part of the equation, as well. And I will just tell you here at the committee level we need help with that. While there are other agencies that have not been as helpful or as forthcoming as they could have been, but CMS does have that data, and we need your help on that.

I have a number of other questions that I am going to submit in writing because I can see Mr. Green is getting nervous, but I do want to thank you for your time today, and I think we have learned a lot

today in this hearing, and I know there was some criticism that we were taking on a little bit too much work, but I think it is important, and I don't think there was anything that we heard today that was superfluous or duplicative or anything that actually wasn't important for us to hear. But I thank you for your testimony.

Let's see. We are going to recess until tomorrow morning at 10:15 at which time we will reconvene with our second panel that is going in a room upstairs. Obviously, Ms. Brandt, you are excused, and we appreciate your participation, but without objection, the subcommittee will go into recess and convene tomorrow morning at 10:15 a.m.

[Whereupon, at 6:00 p.m., the subcommittee recessed, to reconvene at 10:15 a.m., Thursday, April 12, 2018.]