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

THURSDAY, APRIL 12, 2018

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Members present: Representatives Burgess, Guthrie, Barton, Shimkus, Latta, Lance, Griffith, Bilirakis, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Walden (ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor and Kennedy.

Also present: Representatives Kinzinger and Tonko.

Staff present: Daniel Butler, Staff Assistant; Zachary Dareshori, Legislative Clerk, Health; Paul Eddatel, Chief Counsel, Health; Margaret Tucker Fogarty, Staff Assistant; 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; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Health Counsel, Health; Jacquelyn Bolen, Minority Professional Staff; Waverly Gordon, Minority Health Counsel; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Senior Health Counsel; and Samantha Satchell, Minority Policy Analyst.

Mr. Burgess. The Subcommittee on Health will come back to order.

We want to thank our witnesses for being here and joining us again this morning, taking their time to testify before the subcommittee. Each witness will have an opportunity to give an opening statement followed by questions from members.

This is a continuation of yesterday's hearing, so we will not go through opening statements from the top of the dais. People heard enough from us yesterday.

So, today we are going to hear from the Honorable Michael Botticelli, the Executive Director, Grayken Center for Addiction, Boston Medical Center; Mr. Toby Douglas, Senior Vice President for Medicaid Solutions, Centene Corporation; Mr. David Guth, CEO of Centerstone; Mr. John Kravitz, the Chief Information Officer from Geisinger Health System, and Mr. Sam Srivastava -- close enough? -- the CEO of Magellan Healthcare.

And we do appreciate all of you being here with us today.

Mr. Botticelli, you are now recognized for 5 minutes to give a summary of your opening statement, please.

STATEMENTS OF MICHAEL BOTTICELLI, EXECUTIVE DIRECTOR, GRAYKEN CENTER FOR ADDICTION, BOSTON MEDICAL CENTER; TOBY DOUGLAS, SENIOR VICE PRESIDENT FOR MEDICAID SOLUTIONS, CENTENE CORPORATION; DAVID C. GUTH, JR., CHIEF EXECUTIVE OFFICER, CENTERSTONE; JOHN M. KRAVITZ, CHIEF INFORMATION OFFICER, GEISINGER HEALTH SYSTEM, AND SAM K. SRIVASTAVA, CHIEF EXECUTIVE OFFICER, MAGELLAN HEALTHCARE

STATEMENT OF MICHAEL BOTTICELLI

Mr. Botticelli. Thank you, Chairman Burgess, Ranking Member Green, and members of the committee. It is a privilege and honor to be before you again. And I really want to thank you for your continued leadership on this issue.

I really want to focus today on how we can make progress, continued progress, against the opioid epidemic, and particularly the roles of Medicaid and Medicare in combating this crisis.

As I said and as your introduction, I am the Executive Director of the Grayken Center of Boston Medical Center. We are the largest safety net provider in New England with approximately 42 percent of our patients entering through Medicaid and another 27 percent through Medicare.

For decades, BMC has been a leader in treating substance use disorders. Many BMC programs have been replicated not only across Massachusetts, but nationally. The Grayken Center for Addiction at BMC encompasses over 18 clinical programs for

substance use disorders.

I offer my perspective not only as the Executive Director, but with over 25 years' experience in addiction services, having formerly the honor of serving as the Director of the White House Office of National Drug Control Policy and as the Director of the Massachusetts Department of Public Health. My perspective is also as a person in long-term recovery with over 29 years in recovery.

The experience at BMC and in Massachusetts highlight the critical role that Medicaid plays in addressing the opioid epidemic, and this cannot be overstated. The vast majority of BMC patients receiving treatments for opioid addiction have Medicaid, which is widely available to low-income individuals and families and covers a comprehensive set of benefits that allow our providers at BMC to offer our patients the highest-quality care while also at the same time reducing healthcare costs.

Massachusetts Medicaid covers all three FDA-approved medications, includes naloxone on its formulary, and will soon cover residential rehabilitation services and recovery coaching services, all benefits which are not available in many other state Medicaid programs. Sadly, in America today access to treatment is very much dependent on where a person lives.

Among the many bills under consideration by your committee are new opportunities for Medicaid to play a more substantial

role in addressing the opioid epidemic, and here are a few, I think, for action:

All FDA-approved medications for opioid use disorder should be available to patients. Evidence for medication for addiction and treatment is unequivocal. Patients with medication experience significantly improved rates of recovery and, simply put, they don't die. Yet, many settings do not make all or some of the medications available because of coverage rates and often ideas and philosophy. Only one in five people with opioid use disorders receive medication, while the percentage for youth is even less. In the words of Secretary of Health and Human Services Alex Azar, "Failing to offer medication is like trying to treating an infection without antibiotics."

And, like any disease, clinicians need as many treatment tools as possible because what works for one person might not work for the next. However, many patients are limited to what medications they can access, if any. Medicare, for example, does not cover outpatient opioid treatment programs, although there are bills, including one by Ranking Member Pallone, to address this. And also, any federally-funded substance use disorder treatment program that bills Medicaid or Medicare should be required to provide medications consistent with approved best practices.

Medicaid and Medicare should make naloxone universally

available, preferably without a copay. In 2017, Massachusetts for the first time saw an 8.3 percent drop in annual opioid overdose deaths, the first year it decreased since 2010, but at the same time the number of non-fatal overdoses went up. What it suggests is that broad availability of naloxone in Massachusetts is keeping more people alive while the epidemic is continuing to grow. Just last week, the Surgeon General of the United States urged people to carry naloxone.

Overdose data in Massachusetts also show that individuals recently released from incarceration overdose at 120 times the rate of the general public, most often within the first two weeks. This devastating trend emphasizes the need to focus on transitions of care for patients leaving incarceration, as well as treatment during incarceration, as several bills under review by this committee have proposed.

Despite modest decreases in prescribing in the United States over the past few years, prescribing opioids is still a driver of this epidemic. Medicare and Medicaid should mandate that prescribers have continuing medical education around safe prescribing as well as they register and use state-based prescription drug monitoring programs in order to more appropriately treat pain and to diligently track prescribing patterns.

To complement these successful efforts to reduce opioid

prescribing, we need to ensure that patients have access to non-pharmacologic pain management strategies such as acupuncture, physical therapy, and cognitive behavior therapy. Unfortunately, only about half of state Medicaid programs specifically support these services.

Access to services continues to be a barrier in many parts of the country. One study showed that only 40 percent of counties in the United States did not have an outpatient treatment program that accepted Medicaid, and CMS could do more to expand its network.

BMC has many treatment programs that have become national models. The foundation of all these programs is the absence of stigma. Without exception, patients who are aided to recovery at BMC credit the lack of judgment they felt in our programs. Medicaid and Medicare can and should do more to get evidence-based addiction treatment to all these patients. Addiction is a disease, and long-term recovery should be the expected outcome of any treatment.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Botticelli follows:]

**********INSERT 1**********

Mr. Burgess. We thank you for your testimony.

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

STATEMENT OF TOBY DOUGLAS

Mr. Douglas. Mr. Chairman, members of the committee, thank you so much for inviting me to this hearing and your leadership on this issue.

My name is Toby Douglas. I am the Senior Vice President for Medicaid Solutions at Centene Corporation. Centene is the largest Medicaid managed care plan in the country, serving 7.1 million members in 25 different states. I am also the Commissioner on the Medicaid and CHIP Payment and Access Commission, known as MACPAC, and a board member on Medicaid Health Plans of America, a health plan association. And previously, I was a longstanding Medicaid director and behavioral health director in California for the Department of Health Care Services. So, my testimony today is really based on my experience in all these positions as well as my interactions with colleagues in these various states and managed care organizations who are all working together to combat this epidemic.

The epidemic disproportionately affects Medicaid beneficiaries. And a few facts from my written testimony:

Opioid addiction is estimated to be 10 times as high in Medicaid as in commercial populations.

Medicaid beneficiaries are prescribed opioids twice as much as individuals in commercial insurance.

And Medicaid has higher rates of hospitalization and emergency department use for drug poisoning and six times the risk of overdose death.

So, Centene, other Medicaid MCOs, and states are taking a comprehensive approach on prevention, treatment, and recovery. First, we are working with members and providers to prevent addiction from occurring by curbing excessive prescribing patterns. We are preventing overdose. And finally, we are facilitating treatment and recovery in chronic opioid users.

I am going to lay out different areas where Congress can enact policies that really further the ability of Medicaid managed care organizations and states to take a comprehensive approach to prevention and treatment.

First, there needs to be the adoption of best practices and ensuring appropriate prescribing and utilization patterns and increased member and provider education. For example, states and MCOs are taking several actions related to improved formulary management. MCOs and states are removing medications from the formulary that could have a greater potential for misuse. They are limiting early refills and prescription quantities and duration. And finally, some plans, including Centene, are using prescription data to lock in high-risk individuals to one prescriber and/or one pharmacy to fill opioid prescriptions.

Congress should also invest in the development of

continuum-of-treatment modalities, including the use of medication-assisted treatment and ASAM criteria. Several states as well as managed care organizations are working to expand the availability of MAT, recognizing there is a significant shortage in this area, and they are implementing very innovative models that are using the expertise of both a hub, which serves as kind of a center of excellence, and spokes to expand the access to MAT in primary care settings.

Congress should eliminate the Medicaid payment restriction on residential treatment, also known as the IMD restriction in substance use. This is an important component of the overall continuum-of-treatment modalities and should be done within that context of ensuring there are a full continuum of services.

Congress should invest in state adoption of prescription drug monitoring programs and use strategies to ensure all appropriate entities, including both the Medicaid agency systems, managed care entities, and providers have efficient access to PDMP data.

Congress should reform 42 CFR Part 2 to align substance use disorder privacy protections with HIPAA. The lack of alignment between Part 2 and HIPAA really is a challenge for overall primary care and behavioral health integration, and there needs to be the reform to align those privacy protections with HIPAA, but at the same time maintaining the important patient information

around substance use from any type of use for criminal, civil, or administrative proceedings.

And finally, the last point I leave you with is that Congress should look to invest in state officials Medicaid leadership as well as ensuring that leadership is investing appropriately in managed care organizations. States continue to face considerable staff turnover in their Medicaid agencies and leadership. And in order to ensure that states have the right leadership to address this epidemic as well as future public health crises, there needs to be an investment in the appropriate resources, so that both the states as well as the MCOs can execute the right policies.

Thank you very much.

[The prepared statement of Mr. Douglas follows:]

**********INSERT 2**********

Mr. Burgess. We thank you for your testimony.

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

STATEMENT OF DAVID C. GUTH, JR.

Mr. Guth. Thank you, Mr. Chairman, and my thanks to the committee for your comprehensive work on this epidemic that is ravaging our country. I want to say a special thank you to Representatives from our service area, Congressmen Guthrie, Bucshon, Brooks, Bilirakis, Shimkus, and Blackburn.

And I am honored to be here today not only as the voice of my colleagues at Centerstone, but really on behalf of the nearly 180,000 people at Centerstone that we serve each year.

So, a little bit about Centerstone. We are celebrating our 63rd year of service as a not-for-profit behavioral health organization, and we provide a comprehensive set of services throughout our footprint of Florida, Indiana, Illinois, Kentucky, and Tennessee. We also serve individuals beyond that footprint, principally through our network of specialized therapists providing service to men and women who serve this country in uniform and their loved ones.

Do we really know how to treat opioid addiction? Do we have proven treatments and recovery strategies to move people out of opiate dependency and into recovery? And the simple answer is, yes, we do. But, unfortunately, far too few people have access to comprehensive evidence-based treatment they need.

There are many reasons why this is the case. A major

challenge is a lack of providers. We know that there are more than 30 million Americans, living principally in rural communities, who have no access to treatment whatsoever for their condition, let alone comprehensive evidence-based ones.

Another challenge is that in places where treatment options do exist, many available are woefully inadequate. This stems from the fact that fundamentally we do not as a nation treat opioid use disorder like the chronic disease that it is. And despite the body of evidence, there are no standards of quality care that providers are held to and no consistent protocols for care. This is a dramatic departure from our treatment of other severe health conditions. The experience for someone seeking treatment for substance use, opioid use in this case, disorder is entirely different than that of a heart patient. If an opiate-addicted person visits five different treatment centers, they might well receive five different treatment protocols. What happens is where they present makes a greater difference in terms of what they are offered than how they present, and we must change that.

There is no set path a provider is encouraged to follow when no one is holding that provider accountable for administering an evidence-based protocol or for ensuring that the patient has a positive outcome. It is often the case that other healthcare providers that may be engaged in that patient's care around other disorders may not even know that their patient is in treatment

for their addiction, let alone have access to the full medical record.

In short, fragmented care and absence of quality standards and immense workforce shortages result in delayed access or no access at all to lifesaving care. This is what we have to change.

Opioid use disorder is similar to heart disease in that there is no one magic bullet for treating it. You cannot take a pill so that it will disappear. It is a condition based on the patient's presentation and severity that requires a combination of treatments -- medication, therapy, follow-up care -- and a condition that may require significant changes in a person's life to overcome. Fortunately, there is data that shows what can work. This is why we support treatment initiatives that approach addiction as a chronic and relapsing disease with emphasis on building a patient's recovery.

However, in order to ensure positive outcomes, we also need to modernize our health IT infrastructure and optimize our workforce. I realize that saying all of this is the solution is much easier said than done. Getting people in need the right care close to home means dealing with standards of care, infrastructure issues, knowledge gaps, technology gaps, and serious shortages amongst addiction treatment providers.

Fortunately, many of the bills that have been introduced before this committee address these issues. Centerstone

supports all legislative action that eliminates barriers to care and, instead, creates and rewards providers for following quality standards, so that when a patient walks through the door of any treatment provider, they have the best chance of receiving the right services that will help them on the path to recovery.

We support advances in technology-enabled solutions such as prescription drug monitoring programs and incentives to modernize behavioral health IT. Investments in the health IT backbone of our behavioral health system are a critical tool in improving care.

As our chief medical officer often says, the most costly care that we provide across this nation is care that does not work. We must address that.

I am going to leave you with a quick story of a gentleman that received his care at Centerstone. His name is Keith Farah. He is now a peer support specialist at Centerstone. He struggled with severe and persistent addiction for years. As he put it, "I had given everyone who loved me more than enough reasons to give up. I was homeless, unemployed, and a convicted felon. Even worse, I was hopeless and terrified of living life sober." He made the decision to enter into Centerstone's Addiction Recovery Center, and today he celebrates a life he never dreamed of.

So, I know I am out of time here. I just want to say, on

behalf of all of the teams that provide services to our communities, on behalf of the board members that volunteer their time and energies to advance this, I want to thank you for your attention to this and the opportunity to provide commentary. And I look forward to your questions. Thank you, Mr. Chairman.

[The prepared statement of Mr. Guth follows:]

**********INSERT 3**********

Mr. Burgess. Thank you for your testimony.

Mr. Kravitz, you are recognized for 5 minutes, please, for an opening statement.

STATEMENT OF JOHN M. KRAVITZ

Mr. Kravitz. Good morning, Chairman Burgess and members of the Health Subcommittee of the House Energy and Commerce Committee.

My name is John Kravitz, and I am a Senior Vice President and Chief Information --

Mr. Burgess. Mr. Kravitz, your microphone may need to be adjusted.

Mr. Kravitz. Thank you.

So, my name is John Kravitz. I am the Senior Vice President and Chief Information Officer of Geisinger Health System. I want to thank the committee for holding this hearing on a key issue facing the nation, one that Geisinger and healthcare providers are addressing. And that is to combat the national opioid crisis.

Geisinger has employed a multifaceted approach to curb the use of opioids, such as utilizing information technology and electronic prescribing, implementing best practices for pain management, embedding pharmacists in our primary care clinics, establishing drug take-back programs, and others. Collectively, these initiatives have significantly reduced the use of opioids for our patients and members and increased quality of care and outcomes by reducing costs.

With our history as an innovator of health IT and care

delivery models, we saw opportunity to reverse these trends. Our physician leadership proposed, by limiting or eliminating the prescribing of opioids in the clinical setting, Geisinger could minimize and prevent patients' exposure to these drugs and consequent risk of developing an addiction that could lead to overdose or death.

Reducing opioid addictions could also ease the burden on healthcare providers. In an analysis of 942 of our patients who are also insured by our organization, overdoses were found in opioids with steep increases in acute care cost as well as emergency department services prior to an overdose.

We developed and initiated several approaches that focus on changing physician practice patterns to reduce the prescribing of opioids, including creating a provider dashboard which is linked to our electronic health record to identify current practice patterns for our providers. We found that providers greatly vary in their approaches to prescribing opioids, and the smallest number of providers are typically the ones that prescribe the largest number of opioid prescriptions. When we had this information, we could target the outliers and provide them with the best practice for pain management.

This includes the pain management program for surgical patients where we counsel patients and their families to expect some manageable level of pain for minor procedures and the use

of non-addictive alternatives for managing pain. In cases where our physicians believe an opioid prescription is in the best interest, they are highly encouraged to order smaller quantities, seven days or less.

While I am not a clinician, I am pleased that information technology plays an important role in Geisinger's approach to decreasing use of opioids. There are several concerns, for example, with prescribing opioids through a paper process, including drug diversion, prescription forgery, provider DEA numbers being exposed to the public, and doctor shopping to obtain opioids. We have implemented the following initiatives to help alleviate these concerns:

We are tracking documentation on our electronic health records and dashboards that show providers reviewed the mandatory PDMP programs, documenting findings in the patient's medical records. We are integrating specifically from a pain app that we have developed on a mobile device that measures physical activity, patient-reported pain, and other metrics into the dashboard and feeding into the medical record. And finally, we have deployed an EPCS program. Back in August 23rd of 2017 and through February of 2018, 74 percent of our providers of controlled medications have been prescribed through the EPCS system. All 126 of our clinics are on this process and having great success.

Our results are encouraging. We have reduced opioid prescriptions by half since launching these initiatives two years ago, and monthly average of opioids, we had been prescribing about 60,000 per month; we are down to 31,000 and that number is dropping.

Additional information on cost savings we realized from implementing the electronic prescribing of controlled substances were reducing by 50 percent the number of patient calls to determine if their paper prescriptions had been ready for them. So, we initially had about 660,000 calls per year from our patients for opioid prescriptions. We have reduced that to close to 330,000.

With the number of diversions decreasing, we are able to decrease the size of our diversion staff to monitor and manage those, and provider time, most importantly, to write an opioid prescription with the EPCS system had gone from a time period of 3 minutes to write a paper prescription to 30 seconds with the EPCS system. Nursing time as well for opioid scripts went from 5 minutes to 2 minutes. These cost savings accrued approximately $1 million in savings in time and hard-dollar savings for our organization.

Although the dashboard may be unique to Geisinger, we believe other health systems and hospitals can generate similar reports for opioid prescribing, and their electronic health records and

clinical entry systems can do the same work that we have been doing. The initiatives rolled out by Geisinger are broadly applicable to other healthcare systems across the country, and we encourage others to apply these strategies to their organizations. To succeed, organizations need the support of their physician leadership. We are a physician-led organization. This is a process change that has to occur with physicians; it is not technology. Technology is told to support this.

Everything we do at Geisinger is about caring. Part of our caring means that we believe that our members and our patients deserve the best care possible and the best outcomes. That is why we emphasize and support evidence-based medicine and care delivery, including e-prescribing of opioids. The evidence and results are clear. E-prescribing has reduced forgery and diversion while helping patients avoid all unnecessary exposure to addiction and harm.

So, I would like to close out with a couple of concluding comments. We have found that the electronic prescribing process has led to quality improvements in care while reducing opioid prescriptions, drug diversions, prescription forgery, and reducing total cost of care.

Thank you again for the opportunity to provide these thoughts on this critical issue, and I entertain any questions.

[The prepared statement of Mr. Kravitz follows:]

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Mr. Burgess. And thank you for your testimony.

Now, Mr. Srivastava, you are recognized for 5 minutes for your opening statement, please.

STATEMENT OF SAM K. SRIVASTAVA

Mr. Srivastava. Thank you, Mr. Chairman. Mr. Chairman, Ranking Member, and all members of the House Energy and Commerce Committee, thank you for inviting me to testify today on the challenges addressing the opioid crisis and offer thoughts about legislative ideas within the Medicaid and Medicare programs.

Magellan Health is a leader in the management of complex population health. For over 40 years, we have been pioneers in behavioral health, innovators in specialty health, and experts in pharmacy services. We work with health plans, employers, providers, and government agencies, and we serve 25 million people with behavioral health services and 24 million people with specialty health services. We are also privileged to be able to serve a lot of the members here right on our panel today.

We bring a wide range of experience and challenges facing the country with regard to the terrible opioid epidemic. The committee is well aware of the facts of the opioid epidemic. The most recent CDC report says that over 42,000 overdose deaths occurred by opioids in 2016. This is truly a national epidemic, and we commend the committee for its work to develop bipartisan legislation to reduce and prevent addiction and to provide treatment and recovery for those facing this disabling disease. We look forward to continuing to partner with all of you as we

move forward in the legislative process.

So, let me start by saying that the draft bills that have been recently introduced are critically important components to developing a comprehensive response to the crisis. While we have not thoroughly reviewed all of these bills, our initial takeaway is that they point in the right direction and the committee is on the right track.

We need to expand capacity for treatment and recovery services, develop programs for at-risk populations that limit access to highly addictive drugs. We need to allow further access to drug monitoring program data, so providers, health plan clinicians, and care coordinators can access an individual's controlled substances history to identify potentially inappropriate prescribing, dispensing, and the use of opioids and other lethal drugs. We also need to update privacy laws that limit the provider's ability to share information on substance use which may hinder a provider from making informed healthcare decisions. These are all critical components for an overall framework to help address the opioid crisis.

Let me offer a couple of observations. A more detailed discussion of our organization's views can be found in my written testimony to the committee. But expanding access to evidence-based medication-assisted treatment, or MAT, is an important cornerstone to treatment and recovery. MAT combines

FDA-approved medications with evidence-based behavioral health therapies and psychosocial interventions, such as peer recovery and support services, to provide a whole patient approach to treating substance abuse disorder. MAT is a highly effective treatment option and has been shown to reduce drug use and overdose deaths and improve retention in treatment. Now because Magellan believes in MAT as an effective treatment, we are committed to taking steps to ensure that it is more readily available and paired closely to peer recovery and support services.

To further improve the adoption and availability of evidence-based MAT, we recommend expanding the ability to prescribe MAT through the use of telehealth. We also recommend and encourage the use of other practitioners to be eligible to prescribe MAT, such as nurse practitioners and other medical professionals. We ask that the committee also consider a pay bump or other incentives to provide treating patients with a substance use disorder through MAT, and we also encourage that all forms of MAT be covered under Medicare Part B.

A major barrier to care coordination for those who suffer from opioid addiction is the limits of health privacy data regulations placed on healthcare organizations for people with substance use disorders. The vast majority of today's integrated care models rely on HIPAA-permissible disclosures and information sharing to support care coordination; that is, without the need

for the individual's written consent to share relevant medical treatment details between providers.

42 CFR Part 2 currently does not allow the confidential sharing of information on substance use disorder diagnosis and treatment for care coordination or when individuals move from one health plan to another. Excluding substance use disorder from the care coordination hinders the ability to continue to develop comprehensive treatment plans and coordination of services.

Magellan recommends the statute be amended to permit sharing of substance use disorder information for purposes of treatment and healthcare operations, as defined by HIPAA and for medical care. Also essential to the modernization of Part 2 is the express permissibility of substance use disorder diagnosis and treatment information to be included in electronic medical records.

We would like to thank again the committee for the opportunity to offer some thoughts and recommendations on how to address the opioid crisis. Magellan has seen firsthand the magnitude of this crisis, and we are fully committed to continue to provide evidence-based, effective care services to those with substance use disorders. We look forward to working with the committee in partnership to address the critical crisis facing our nation. Thank you.

[The prepared statement of Mr. Srivastava follows:]

**********INSERT 5**********

Mr. Burgess. Thank you. I want to thank all of our witnesses for your testimony and participating with us this morning.

And now, we will move into the question-and-answer portion of the hearing. Before beginning questioning, I would like to submit into the record a statement from the American College of Obstetricians and Gynecologists. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 6**********

Mr. Burgess. I would also like to submit for the record a New York Times article entitled, "Medicare Is Cracking Down on Opioids. Doctors Fear Patients Will Suffer." I would like to submit that for the record. Without objection, so ordered.

[The information follows:]

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

Mr. Burgess. And let me recognize myself, 5 minutes for questions.

Mr. Douglas, I think in your testimony -- and I think it actually comes up as a repetitive theme -- but just looking at your remarks that you have provided to the committee, "Opioid addiction is estimated to be 10 times as high in Medicaid as in commercial populations," and then, you go on to delineate some other statistics that indicate Medicaid beneficiaries are prescribed opiates twice as often as individuals with private health insurance.

I am going to ask you this question; you may not know the answer to it. I may be able to find the information elsewhere. But when was this phenomenon recognized? Is this relatively recent or this is something that has gone on for -- I mean, Medicaid has been around since 1965. Has this been recognized in the '60s and '70s or this is a more recent phenomena?

Mr. Douglas. I don't have the exact timing. But what I would say, given my previous life as a Medicaid director, that part of the phenomena within Medicaid is the growing role of Medicaid and being a broader program than just physical health. This problem in many ways was siloed off, with substance use being a separate program run in many cases in states by separate agencies.

And what we went through in the evolution in around 2010-11

was acknowledging the importance of integrating in California behavioral and physical health. That started to drive more of Medicaid and, then, our more integrated MCOs to work to solve and recognize the impact it was having on inpatient, on emergency room utilization. It was impacting medical spend and the outcomes and the need to expand services, which is why California started moving forward with how do we expand and integrate, as well as acknowledging there was actually with a siloed program a lot of unfortunate fraud going on within our substance use program, and the need to integrate into a system would allow for making sure the right care and the continuum is being provided.

Mr. Burgess. And again, is that a more recent phenomenon or was that something that has just been longstanding?

Mr. Douglas. I would say, again, I can't speak to -- as I said, the Medicaid agencies were starting to deal with this. As I said, when I look back on my time around 2010, around there, it was starting to become more and more of the need to think holistically about behavioral and physical health integration and brought these to the head.

Mr. Burgess. And I actually would be interested in what other panel members have to say about this. I am not asking the question to be provocative. It is just that we are the payer here. The federal government is the Aetna, United, the Cigna. We are the payer. And if there is something about our structure

that is putting people at risk, then I think we need to recognize that, and if there is a way to mitigate that risk, we ought to do so. So, are there any other thoughts that any of you have as to whether the identification of the type of coverage putting someone at risk, is that a real phenomenon or is that an observer bias?

Mr. Botticelli, you look like you want to make a statement.

Mr. Botticelli. I do, and no disrespect to Mr. Douglas. While we, I think, know the prevalence of substance use disorder in both Medicaid populations is high, and higher than the general population, there was a recent Kaiser health survey that just came out that shows the growing trend of substance use disorders and opioid use disorders prevalent in both commercial and employer plans. So, again, I think that while we do see slightly higher rates among Medicaid populations, I don't think that the differences are as vast between kind of the Medicaid population and the commercial market as one would have previously thought.

Mr. Burgess. So, we can effectively ignore the type of coverage? It is of no consequence?

Mr. Botticelli. No, coverage is significantly consequential because I think what we also see in other studies is that coverage, quite honestly, accelerates access to treatment, and we have seen it with both Medicaid and commercial plans.

Mr. Burgess. So, intuitively, yes, that would be obvious.

I am going to run out of time.

And, Mr. Douglas, I also want to mention, thank you for bringing up Project ECHO, which was a product of this committee. And many of you have mentioned prescription drug monitoring programs and, of course, the NASPER authorization originated in this committee back in 2005. So, although the focus recently has been more intense, this subcommittee has been dealing with this problem for some time.

I see my time has expired. I am going to yield to Mr. Green 5 minutes for questions, please.

Mr. Green. Thank you, Mr. Chairman.

And again, I thank all our panelists.

One of the biggest issues of Americans struggling with opioid addiction and substance abuse generally are the barriers to treatments and ensuring there is a continuity of coverage, and particularly for vulnerable populations. Just that exchange, Dr. Botticelli, the compare between private insurance and Medicaid, at one time I assumed Medicaid was more. Coming from an urban area in Houston, Medicaid is such a predominant care for not only physical care, but also mental care. And my concern, Mr. Douglas, is that, if you are splitting off that, I think it ought to be a continuity of care between the physical doctor and -- because, obviously, we know the behavioral and the physical

is important. So, we need to have that coordination of care, whether it is through Medicare or the private sector, or whatever.

What would be the consequences if it becomes more difficult for Americans struggling with substance use disorders to receive Medicaid coverage?

Mr. Botticelli. I think we have seen, yes, we would not be able to do what we do at Boston Medical Center were it not for a generous benefit through Medicaid. And not only do we see successful clinical outcomes on both the behavioral and the physical side, but we have also been able to demonstrate that we can actually lower healthcare costs by giving people good, comprehensive, quality care. We have seen, if we can get people in treatment, we can reduce emergency department admissions and hospitalizations, as well as get them to long-term recovery and really kind of miraculously return people to jobs, to the community.

I think, without coverage -- and we have seen time and time again the devastating impact -- that one would anticipate that we will see significant increases not only in mortality, but we are also dealing with other epidemic issues of hepatitis C. We are seeing outbreaks of HIV across the United States. And so, you are entirely correct that this is not just about adequate access to substance use treatment, but people need adequate access to the entire spectrum of physical health issues.

Mr. Green. I was interested, Mr. Douglas, in saying, in 2010, you saw the more concern or interest, and it was because of the separation maybe from behavioral care as compared to physical care. Was that because of the Affordable Care Act getting ready to kick in or expansion of private sector funding because of the Exchanges?

Mr. Douglas. So, again, this is really, I want to say, through my lens in California as well as on the National Association of Medicaid Directors, working with Medicaid directors at that time again, of Medicaid directors' acknowledgment. And I would believe that there were many factors. I think the Affordable Care Act was one of them, of understanding both looking more at how we were -- at that time the Affordable Care Act, besides the expansion, was really focused on integrating care, as you said, of physical and behavioral health and aligning the right payment incentives and outcomes. And so, states were really looking holistically and realizing that, to address better health outcomes, there needed to be more integration and expansion of treatment modalities within behavioral health and substance use.

And so, we are now in Centene, and where we stand is we do still see differences by states in the availability and access to substance use treatment services, and it varies. While Medicaid has a richer benefit, it still varies in terms of the

availability of substance use. In states where we do have Medicaid expansion, we are seeing the ability in the data of being able to address unmet need more within the substance use area.

So, it is a combination of factors. I don't want to say that the ACA didn't; the ACA spurred both expansion of benefits as well as thinking through how to integrate physical and behavioral health, as you said is so important.

Mr. Green. Thank you.

Mr. Chairman, you and I have had the opportunity, and a number of our members on both sides of the aisle, to attend the Commonwealth and the Alliance. Once a year we go off for a long weekend and have folks.

Mr. Kravitz, Geisinger, for a number of years, has been at those facilities. And coming from a guy from Texas with my accent, I didn't know anything about Geisinger until then. But, then, I happened to have my father who moved back home, so to speak, from Houston, to northern Pennsylvania. He was a patient there. During his lifetime -- he lived to be 91 and a half, a great life -- but I was really impressed by Geisinger's facility there treating the whole person.

Mr. Kravitz. Thank you.

Mr. Green. Anyway, I am out of time, Mr. Chairman. Thank you.

Mr. Burgess. The Chair thanks the gentleman.

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

Mr. Griffith. Thank you very much, Mr. Chairman.

And thank you all for being here today to testify.

Mr. Douglas, the Centers for Medicare and Medicaid Services recently released its 2016 Drug Utilization Review Report. The report noted that 26 Medicaid agencies have access to prescription drug monitoring program data. States can use this data from the PDMPs to manage the overutilization of opioids and detect fraud, waste, and abuse. On the other hand, 23 state Medicaid agencies report that they do not have access to the PDMP data. Can you describe how Medicaid agency officials would use PDMP data to combat opioid misuse?

Mr. Douglas. So, both, again, from the view of talking with both current and former state Medicaid directors as well as managed care organizations, the use of PDMP is really, really important in combating. We have seen effective use in ability to both make sure that our providers, they understand and have a clear sense of where our members are receiving other opioid prescriptions. And so, it creates alerts. It creates information that we can then, as we go through utilization management back as a managed care organization, to be able to create and prevent prescribing from occurring.

And so, in the cases where we have it, it effectively improves

our ability to combat inappropriate prescribing patterns and utilization. And so, as I noted in my remarks, this is an area where I think Congress could do a lot in both incenting states to make sure that all entities, both the agencies, the Medicaid agencies, the providers, as well as the managed care organizations across all states and territories, have access to the data to combat and ensure there is judicious prescribing.

I would note -- and I think you heard from some of my colleagues -- that that is not going to be sufficient. We have to also figure out how to overlay this into EHRs and make sure it is as easy as possible for our providers. We are at Centene trying to do that, but it is more than just a role of managed care organizations to be able to solve this. It takes investment in IT systems and prescribing to make sure that there is easy utility and it fits into the workflow of our providers.

Mr. Griffith. One of your suggestions for ensuring all appropriate entities have access to PDMP data is to proactively share that data, the data reports, with each other. Can you explain how this would work in practice?

Mr. Douglas. Well, this gets, again, to in practice the importance of IT, because, as providers work, it needs to be real-time. In terms of our responsibility for utilization management of pharmacy, there are requirements on turnaround times. And so, if the information is not shared quickly and

through electronic means, we are either going to be out of compliance with our utilization management or providers are going to have problems within their workflow.

And so, in practice, it makes sense. In the actual real life right now, until we get better IT systems across all systems -- I am sure in Geisinger and others it is there -- but we need, especially with Medicaid providers, more investment.

Mr. Srivastava. So, Congressman, if I could add?

Mr. Griffith. Yes, sir.

Mr. Srivastava. One is it is spot on that with PDMP we are data-rich, but we are processing-poor in this construct. You need interoperability to share it with health plans that share it with pharmacy providers and with providers. It needs to be at the workflow level, so that it is in an EMR. But, also, you are getting data that is not just those that are prescribed, but also cash pay. So, if a person seeks drugs, and it is through the benefit in Medicaid or the benefit within your employer, you are going to get information. But, if you are actually going and cash paying for drugs, that processed claim would also show up in this report. So, we are getting more data sources, and it needs to be at the point of care, where the individual can act and understand whether there is a lot of drug history there, to be able to change the regimen.

Mr. Kravitz. I would like to also add a comment, if you

don't mind.

Mr. Griffith. Yes, sir.

Mr. Kravitz. From an information technology perspective, we use PDMP before any opioid is being prescribed for a patient. What is important, though, is not all states have reciprocity where they can go through and exchange information. We actually need to go to a level where we are closer to a national PDMP for patients traversing different state lines. Where there are reciprocal arrangements that are occurring, not all states participate. The other problem that is a national problem is a national patient identifier to make sure we have the right patient identified in the PDMPs.

The other component of that, while we have advanced IT systems, we don't have the ability to put it into our workflow because our Commonwealth of Pennsylvania does not have APIs established yet to do that. We will have those in the next three months. We will automate that entire process, so that it doesn't have to take the provider out of the workflow, but trigger those events in the background. So that they know if a patient is traversing multiple locations to try to get opioids.

Mr. Griffith. I appreciate that, and I will have additional questions for the record.

[The information follows:]

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

Mr. Burgess. The Chair thanks the gentleman.

And, Mr. Kravitz, I would point out that NASPER, which was the national PDMP authorized by this committee in 2005, for the first time it was funded in the last funding bill that we just passed a few weeks ago. So, we are moving in that direction. It takes us some time, but we are getting there.

The Chair now recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for your questions, please.

Ms. Schakowsky. Thank you, Mr. Chairman.

And speaking of what direction we are moving in, today's hearing on Medicaid and Medicare proposals to address the opioid epidemic actually comes on the same day that the House is considering the balanced budget amendment. I just want to comment on the effect that would have.

If enacted, the balanced budget amendment would undercut the structure of Medicare and Medicaid by opening both to dramatic cuts in funding. Republicans passed what I believe is a misguided tax bill that blows a $1.5 trillion hole in the budget, gives 83 percent of these tax cuts to the wealthiest among us. And we see Republicans offer budgets that would fill that gap by cutting more than $1.5 trillion in Medicare, Medicaid, and Social Security. And now, Republicans want to amend our Constitution to require that we can only spend in any given year what we raise

in tax revenue in that same year, after just cutting those revenues. So, this is a serious threat to Medicaid, which is on the frontline of fighting the opioid epidemic, as we have been talking about.

So, let's see, who am I asking? Mr. Botticelli, what are some examples of the actual services that Medicaid programs cover for substance use disorder treatment?

Mr. Botticelli. So, Medicaid -- and I will talk specifically about a program that we have at Boston Medical Center --

Ms. Schakowsky. Okay.

Mr. Botticelli. -- where we have virtually 100 percent of our people who are Medicaid-eligible. That program serves over 700 people within the context of our adult primary care clinic. What we have been able to demonstrate through that is, at 12 months, we have 65 percent of people still engaged in treatment at 12 months or longer.

But I also think what is important, too, is, as I indicated, because of that program, we have been able to do a retrospective study of utilization of healthcare services prior to people getting treatment and, then, in the duration of treatment afterwards. What we have been able to show is we could actually reduce -- emergency department admissions go down by two times and inpatient hospitalizations go down three times. So, not only

do we see our ability to provide good, high-quality care for treatment, but, simultaneously, we are able to reduce healthcare costs for some of the highest utilizers of health care, not only within Boston Medical Center, but within our larger healthcare delivery system.

So, I think that is a really good example, and part of the reason that we are able to do that is through our Medicaid program, and largely because they also fund a whole host of medication-assisted treatment, a wide variety of other recovery support services that our patients need access to. So, I think it is a good example of kind of the critical nature of our ability to execute high-quality care because of our patients access to Medicaid.

Ms. Schakowsky. So, I am assuming, then -- my next question, you sort of answered it in the positive -- it would be the negative. What would a drastic cut in Medicaid specifically mean for those enrollees receiving the care that you have outlined?

Mr. Botticelli. I think it would be devastating, and I don't think I am overexaggerating kind of the impact that that would have for our patients' ability to access care. I think it is very hard.

And I was actually the Director of Treatment Services in Massachusetts prior to healthcare reform and prior to Medicaid. So, I saw the issues that people had not only in terms of their

ability to access care, but also some of the devastating consequences that we see.

I think Massachusetts is a good example of being able to achieve some modest reduction in overdose deaths, unlike many, many states across the country. And I think part of the reason that we are able to do that is because of our patients' abilities to be able to access treatment when they need it.

Ms. Schakowsky. So, you are saying "modest". Why isn't it robust, for example, in lives that are saved?

Mr. Botticelli. Well, I guess, if you are one of the 10 percent of people that your life was saved in Massachusetts, that is robust. I think why I am kind of cautious is because deaths are still too high. Again, I think while we are all cautiously optimistic that a 10 percent reduction is good --

Ms. Schakowsky. It is good.

Mr. Botticelli. -- it is moving in the right direction, it is still way too high. And we still had over 2,000 people in Massachusetts die in 2017, and that is just way too high, despite a 10 percent decrease.

Ms. Schakowsky. I am just going to skip to, what services can health homes provide for those with substance use disorder?

Mr. Botticelli. Actually, Mr. Douglas mentioned one. Vermont is a really great example of how you use health homes to not only increase access to treatment, but increase access

in rural parts of the country. So, they use what is called a hub-and-spoke model where they induct people in the hubs and, then, move people to primary care sites in the spokes. And I don't know the latest data, but they have been able to really significantly increase access to treatment. I think Rhode Island as well has utilized the health home model to dramatically increase access to treatment. So, I think a number of states have used this, but I also think it is really important, as we think about how do you push out treatment to rural parts of the country that don't have a treatment program and don't have providers. I think medical homes, some states have really implemented innovative programs to be able to do that.

Ms. Schakowsky. So, I am out of time. Mr. Douglas, so Vermont is an example of how it can work?

Mr. Douglas. That is correct, and it is spreading to other states. California, too, is doing it. It is an investment, and this is an important piece. The resource shortage can't just be dealt with on substance use providers. We need to spread the best practices back into the physical health and the primary care, knowing that the expertise would be in the substance use treatment centers, but this hub-and-spoke, this idea of working together and providing the expertise and creating the incentives to do that through health homes and ways to share. And telehealth and other opportunities are great ways that we can better integrate

the systems.

Mr. Burgess. So, the short answer was yes.

Ms. Schakowsky. Thank you.

Mr. Burgess. The gentlelady's time has expired.

The Chair recognizes the Vice Chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. Guthrie. Thank you very much. I appreciate it very much.

These questions are for Mr. Srivastava. Johns Hopkins University and the Clinton Health Foundation released a document in 2017 that contained a number of recommendations for combating the opioid crisis. One recommendation was to support restricted recipient programs, otherwise known as lock-in programs, for at-risk populations. From what I understand, lock-in programs are designed to restrict overutilization of opioids and to identify potential fraud and abuse of controlled substances.

Mr. Srivastava, can you talk about if you organization has been involved in a lock-in program and if you have found the program to be useful in combating opioid abuse?

Mr. Srivastava. Thank you, Congressman.

In terms of lock-in programs, we actually support over 100 health plans across the country and serve their Medicaid and commercial and Medicare needs. So, we have experience working with Medicaid lock-in across the country. We also have our own

special needs plans in Florida, Massachusetts, New York, and Virginia.

Our experience has been in our special needs plans where within Medicaid we have had the ability to lock in on prescribers where there was a lot of overutilization. There was multiple providers as well as multiple use within a period of time.

Today what we are finding is state by state there is different criteria. So, for example, in Florida, you have to have three prescriptions, three providers, and three different settings, and claims within the last 180 days. But we found that lock-in allows for, one, an integrated care plan to be developed for the individual. Two, it eliminates a lot of kind of drug-seeking behavior. And then, three, it allows for kind of transition beyond managing the pills themselves, but actually helping the individual to get support cycle social support services and treatment and recovery services afterwards.

So, we are finding that there has been good evidence that lock-in programs work in Medicaid. It will be launched, I believe, in 2019 for Medicare as well. And so, general expectation is you will see a broader user of that program.

Mr. Guthrie. Okay. Thank you. And I have another question for you. Some have expressed concern with going to the HIPAA standard for substance abuse/use disorder records for the purposes of treatment, payment, and healthcare operations because

they are afraid the record will get into the wrong hands and they will be fired from their job.

Can you tell me what are the activities that fall under these three categories, so we have a better understanding of why it is so important to have access to a patient's record for treatment, payment, and healthcare operations?

Mr. Srivastava. So, confidentiality is critical and important. And this kind of speaks to CFR 42 Part 2. Historically, all of how providers communicate and coordinate with health plans and with facilities to coordinate care has been to get a release under HIPAA to be able to maintain confidentiality to provide care.

And what is happening is we have kind of stigmatized those individuals with substance use disorder and created CFR 42 as an added layer of protection. It has actually limited a provider's ability to actually coordinate care effectively.

And so, our recommendation is to think through and expand and modernize CFR to be regulated under HIPAA, which is confidentiality. But that, if an individual happens to have diabetes and has a substance abuse issue that they are seeking care from a provider, and then, they go to an outpatient setting or they go for treatment and recovery services, or they go to a dentist, that we are not having to, as a health plan be able to, or as a PCP be able to get permission from each individual

provider to be able to coordinate the care.

At times, we don't know that that occurs. And so, as a result, there can be kind of misuse, and as a result, can also be adverse outcomes.

Mr. Guthrie. So, if you use that information, what prevents an employer from having access to it?

Mr. Srivastava. Under HIPAA guidelines today, we are managing, as a health plan or as a provider, we are confidentially treating individuals who have cancer, individuals who might have AIDS/HIV, or any sort of kind of behavioral health SMI disorder, and we don't communicate that with the employers. So, we are kind of bound by HIPAA. We are also bound additively by CFR 42. So, from our perspective, it is confidentiality, and we are kind of trained as healthcare professionals not to be able to share that information beyond what is needed for a treatment plan and to be able to service the provider.

Mr. Guthrie. Okay. Thank you. I thank you for your answers.

And I yield back my time.

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

The Chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for your questions, please.

Mr. Engel. Thank you, Mr. Chairman, for holding another

hearing on this important topic.

In Westchester County, part of which is in my district, 124 people died due to opioids in 2016, and in the Bronx, New York, which is part of my district, more in New York have died of overdoses than in any other borough of New York City.

We must do more to turn the tide of the opioid epidemic, and we cannot hope to do that if we fail to recognize the importance of Medicaid. Medicaid covers nearly 4 in 10 non-elderly Americans grappled with an opioid addiction. Through the Medicaid expansion under the Affordable Care Act, states were afforded new resources to cover Americans living with substance use disorders and get them the treatment they need. We must continue to expand states' capacity to combat the opioid crisis and take care to avoid hamstringing that capacity in any way.

This brings me to a number of bills we are considering today that I fear could hinder states' ability to address this crisis, the Medicaid Pharmacy Home Act, the Medicaid Drug Improvement Act, and the Medicaid Partnership Act. I worry that asking states to make complicated changes to their Medicaid programs in less than a year sets them up for failure. And since non-compliant states would be punished with FMAP penalties, states' ability to deliver treatment and recovery services could be hampered as a result.

I also have concerns regarding the Medicaid Graduate Medical

Education Transparency Act. In my opinion, the reporting required under this bill is overly prescriptive and burdensome and may take the limited resources states have for Medicaid GME and offer reporting that will not tell us very much. And I have heard similar concerns from stakeholders as well. After all, Medicaid spending constitutes just 16 percent of federal spending on GME. So, this reporting would offer an extremely narrow picture of the training physicians are getting.

I also worry that the information gleaned from these reporting requirements could be viewed as a microcosm for state Medicaid programs' holistic efforts to combat the opioid crisis, but it is my understanding that those efforts involve many facets of the healthcare system, not just physician training.

So, Mr. Douglas, I want to ask you, is that a fair assessment, that the efforts involve many facets of the healthcare system, not just physician training, and that information gleaned from these reporting requirements could be viewed as a microcosm for state Medicaid programs' holistic efforts to combat the opioid crisis?

Mr. Douglas. I am sorry, the question?

Mr. Engel. Okay. Let me move on. I am not opposed to collecting more data on Medicaid GME or other GME programs. However, I think we need to be more thoughtful about the data we are asking states to collect when facing a shortage of

providers, of said providers. But I don't believe this bill would address that, and solving the problem cannot be left solely to a group of specialists with specific training in substance use and addiction. A more comprehensive approach is needed. We need to be thinking about the full spectrum of providers and their roles in solving this crisis.

Mr. Douglas, let me try again. How can we improve and build our workforce so that said providers and others can help end this epidemic?

Mr. Engel. Great. As I noted in my written testimony, as well as the chairman mentioned, I think an important area we are focusing, as a managed care organization at Centene as well as states, is around ways to make sure that we are educating providers and disseminating that education. Project ECHO is a great way of doing telementoring opportunities and really spreading, especially as it gets to rural and underserved areas. So, we have to focus both from making sure we are educating on the prevention side, but, then, as you noted, there has to be a continuum of service as the treatment modalities. From the lens of MACPAC that we have seen identified, there is a wide disparity, that you might have in Boston a larger rate of treatment modalities, but in many states the modalities aren't all there. And so, the continuum of services on the treatment side from both outpatient to peer support, to MAT-related services, and,

of course, as I mentioned before, there needs to be residential, where appropriate, on the evidence-based, and that means eliminating the IMD exception. So, those are all approaches that need to be taken.

Mr. Engel. Thank you.

Let me quickly go to Mr. Botticelli, based on some of the comments that were made before I gave my question. Do you have any concerns about rolling back 42 CFR Part 2?

Mr. Botticelli. I do, both as a policymaker and a person in long-term recovery. Unfortunately, substance use disorders are different from other diseases. They are still highly stigmatized. They are subject to discrimination and criminal penalties.

SAMHSA, I think -- and this is fully supporting the fact to give people good care, we need to integrate physical care with part of their substance use disorder treatment. I think all of us support better integrated and holistic care. But I do think a patient should have a right to consent to disclose their records. The Substance Abuse and Mental Health Services Administration actually just modified their regulations twice to support enhanced integration of 42 CFR Part 2 information, treatment information, into primary care records.

Mr. Engel. Thank you.

Thank you, Mr. Chairman.

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

The Chair recognizes the gentleman from Illinois, 5 minutes for your questions, please, Mr. Shimkus.

Mr. Shimkus. Thank you, Mr. Chairman.

Great to have you all here.

Mr. Botticelli, you were with the previous administration, were you not?

Mr. Botticelli. I was.

Mr. Shimkus. And what was that position again?

Mr. Botticelli. I was the Director of the White House Office of National Drug Control Policy.

Mr. Shimkus. Yes, great. Thank you for your service. And to segue now into what you do in Massachusetts, I think it is important. And this is an all-hands-on-deck process. Obviously, we are trying to do our best to affect the public policy and to help you all do your job.

But let me go to, in your testimony you mentioned one report which found only about half of the state Medicaid programs currently cover non-pharmacological alternatives to pain such as, as you have talked about, cognitive behavior therapy and physical therapy. Mr. Douglas, the committee has heard from Medicaid directors about the importance of federal funding for evaluation of non-pharmacological alternatives to build strong

empirical basis for making coverage decisions.

Could you both please talk about the degree to which you think this research about the utility and cost-effectiveness of non-opioid alternatives already exists and what more Congress or CMS can do to help state Medicaid programs have the information needed in making coverage decisions that ultimately impact patients?

Mr. Botticelli. Great. I will start and, then, turn to Mr. Douglas.

Throughout the course of our work area, I think we have to be very careful, while we know we want to make sure that we are diminishing opioid prescribing, that we are giving patients access to really good pain management therapies. I think we are hearing more and more stories, quite honestly, of patients in legitimate pain not being able to access non-pharmacologic approaches. And so, I think we have to couple our efforts with not only opioid reducing, but making sure that we are giving people good access. We do have a number of evidence-based -- and we need to continue to research non-pharmacologic approaches. We know acupuncture works. We know physical therapy works, yoga, exercise.

And so, again, I think if you talk to our clinicians at Boston Medical Center who deal with both substance use disorder and pain, that because our Medicaid program actually supports a wide variety

of non-pharmacologic approaches, we are able to give patients good pain care and at the same reduce opioid prescribing.

Mr. Shimkus. Mr. Douglas?

Mr. Douglas. Yes, I would just echo the points of Mr. Botticelli that there needs to be more work on this. Both from a state as well as an MCO perspective, we are continuing to want to ensure that we are doing evidence-based practices on treatment modalities. And that gets to being able both from a state policymaker to be able to give the Medicaid agencies the ability to test new treatment modalities or ensure that those modalities are being executed on. And so, without the evidence, you have disparity across states as well as you have a harder time for MCOs to get the best practices and the right care and the right setting to be provided. And so, we encourage there continue to be work in this area.

Mr. Shimkus. Yes. So, I will ask you to take this back and maybe submit and maybe submit some more information. And I appreciate that, but the question is, what can we more do legislatively or what can CMS do to help fill this space to give the information needed to help?

So, my follow-up question is going to be, one of the most dangerous things about opioids is that they are cheap or at least much cheaper than non-opioid alternatives, some. And your testimony and Mr. Botticelli also underscores the need to

complement the largely successful efforts to reduce opioid prescribing. We need to ensure patients have access to non-pharmacological pain management practices. To that end, several of us on this committee have expressed concerns about the declining Medicare reimbursements for certain pain management procedures frequently performed by the ambulatory surgical centers because they are more expensive.

Can you talk about the importance of incentivizing non-opioid, non-pharmacological treatments and stemming the tide of opioid addiction, particularly as it relates to patients' access, Mr. Botticelli? And then, I want to go to Mr. Kravitz to answer this.

Mr. Botticelli. I think part of the reason that we are in the predicament that we are in is that writing a prescription for opioids is not only far cheaper, but it is also far easier for the clinician to be able to write a prescription versus having a conversation with their patient on pain and pain expectations and pain management.

So, I think both CMS and Medicare need to do everything that they can, quite honestly, to provide financial incentives that drive toward those other kind of pain management therapies. While there might be some modest cost increases in the short term in terms of those strategies, I think the return on investment of not getting people addicted and not having to go through all

the other medical expenses probably far outweighs any modest increase in cost for those therapies.

Mr. Shimkus. Thank you.

And, Mr. Chairman, can Mr. Kravitz answer that?

Mr. Kravitz. Yes. So, at Geisinger Health System, we are very much in a consultative measure with our patients as well on the same topic. We take the time to counsel them and to look at all other alternatives for treatment for these patients. So, especially chronic disease patients, as I stated in my opening statement, we utilize things like rehabilitation, Tai Chi, yoga, things of that nature, to alleviate pain. And they have been proven to be successful.

In cases where they are not the case, where opioids do have to be prescribed, we are very careful and judicious to not extend an extensive prescription quantity for those patients. So, they don't have the opportunity to get addicted to opioids.

Mr. Shimkus. Thank you very much.

Thank you, Mr. Chairman.

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

The Chair recognizes the gentlelady from California, Ms. Matsui, 5 minutes for your questions, please.

Ms. Matsui. Thank you, Mr. Chairman.

And I want to thank the witnesses for being here today.

I also want to say, Mr. Chairman, thank you for holding this third hearing today on legislation to address this opioid epidemic. It is so important that we are focusing on a variety of perspectives on how to solve this crisis. We know the problem is multifaceted and the solution will be, too.

And I just want to also point out the importance of the Medicaid program in addressing this crisis. Medicaid serves a large proportion of the population with substance use disorder, and any effort to cut the program's funding will severely jeopardize access to those services.

I also must say, while we must act urgently, I am concerned that, if we move the nearly 70 bills through our committee too quickly, some of the policies will have unintended consequences that will contribute to the problem rather than the solution. And I look forward to further discussions with my colleagues and stakeholders as we ensure that these policies are going to be as effective as possible.

I think that the biggest potential for transforming our healthcare system lies in the power of technology. Electronic health records have the potential to streamline care, increase coordination of care across providers, and aggregate data for population health management and research purposes. Telehealth provides the opportunity to get care to patients faster or in cases where they can't otherwise have the access to the

appropriate provider.

This has a huge potential to help us address the opioid epidemic. Technology can help us to integrate the behavioral health care and physical health care, treating a person as a whole and ensuring that all of their needs are met in a timely manner. Most people with a substance use disorder have an underlying mental health issue and/or physical condition. If all conditions are not addressed, we will have less success in treating the addiction.

One of the ideas I am working on with Representatives Mullin and Blumenauer is how we can assure that substance use information can be shared for the purposes of care coordination and patient safety without infringing on patient privacy rights. None of that work will have any effect, though, if substance use and behavioral health providers don't even have electronic health records to facilitate the data sharing.

That is why I co-lead H.R. 3331 with my colleague on the Ways and Means Committee, Representative Jenkins. Behavioral health providers were left out of the Meaningful Use Program which encouraged adoption of electronic health records by hospitals and doctors. This would certainly extend an incentive to behavioral health providers via a demonstration project.

Mr. Kravitz, my understanding is that your organization has been successful as a result of investing in electronic health

records. Could you please describe how electronic health records have improved quality of care and reduced cost?

Mr. Kravitz. Yes, I am happy to, Congresswoman. So, we have invested in electronic health records back in 1995. I think we were one of the earlier adopters of the EPIC electronic health record system, which has been predominantly used between EPIC and Cerner across the country with all scripts.

We have also invested heavily in analytics. In fact, we have a big data platform similar to Google, and we look at that data all the time. We analyze the data very carefully. In fact, one of our scenarios, we did a 10-year study with Geisinger Health Plan, which has 580,000 members in our population. We looked at that data very, very carefully, and that is where we recognized and realized that patients on opioids that were part of that process had higher levels of acute care stays before they had overdoses as well as ED visits were tremendously increased over the last 22 to 12 months prior to an overdose occurring.

So, information is key. The ability to integrate that data and interoperate that data with other systems is extremely important.

Ms. Matsui. So, you believe that this will be helpful to extend this to behavioral health providers?

Mr. Kravitz. Absolutely.

Ms. Matsui. Okay, great.

Mr. Kravitz. Absolutely.

Ms. Matsui. Well, let me just right now, also, submit for the record here a letter from the Behavioral Health IT Coalition, which includes the American Psychological Academy, NAMI, Mental Health America, the National Council of Behavioral Health, in support of H.R. 3331, for the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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

Ms. Matsui. I also want, Mr. Douglas, thank you for your past service as a Medicaid director.

I currently have another bill coauthored with my colleague, Representative Harper, that will allow behavioral health clinics to register with the DEA to be able to use telemedicine to prescribe controlled substances, increasing access to medication-assisted treatments in our communities.

Can you describe the benefits of medication-assisted treatment and detail the current barriers you see that might prevent its expansion?

Mr. Douglas. Thank you.

So, as I mentioned in my written testimony, the expansion of medication-assisted treatment is a really important component of the overall continuum, especially as we learn and have substance use treatment providers working with primary care. As you said, being able to create more technology interfaces will be an important way to work across this idea of a hub-and-spoke with our primary care and sharing data back and forth. And so, as we are looking at more a holistic approach to medication-assisted treatment and primary care integrating with it, what you are laying out would really solidify and improve the infrastructure.

Ms. Matsui. Okay. Thank you.

And I have run out of time. I yield back.

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

The Chair recognizes the gentleman from Texas, Mr. Barton, 5 minutes for your questions, please.

Mr. Barton. Thank you, Mr. Chair.

I have a question for the chairman before I ask a question of --

Mr. Burgess. The answer is no.

[Laughter.]

Mr. Barton. I was going to say, did you think you are the greatest Health Subcommittee chairman we have ever had?

[Laughter.]

Mr. Burgess. No, that would be Governor Deal.

Mr. Barton. We have got about three dozen bills that we are looking at. Is it your plan to move all of these bills individually, collectively, some of them, none of them? What is the --

Mr. Burgess. Well, as you will recall from my opening statement yesterday and previous opening statements in previous hearings that we have had -- I am assuming the gentleman is yielding to me for an answer.

Mr. Barton. Yes, sir, of course. I wouldn't ask a question if I didn't want you to answer it.

Mr. Burgess. I don't have a precise answer to your question,

but the fact that we are considering so many bills, and some of the bills we are considering are, in fact, still in draft form, we do want to be inclusive. We have done a significant amount of outreach. As you will recall, we had a many-hour hearing in this subcommittee in October where we invited every Member, not just from the committee and subcommittee, but from the entire Congress to come and share with us their thoughts on what the opioid epidemic looked like in their districts and how they were reacting to it, and ideas that they had. As a consequence of that interaction, a number of ideas were presented to the subcommittee, and we have been over the last several months going through those. Right now, most of them are in individual bill forms. It is quite likely there is some duplication; there is some consolidation that is available.

And as you will recall from bills like the Comprehensive Addiction Recovery Act from the last Congress, the Cures for the 21st Century, ultimately, numerous bills were consolidated into one larger bill. That could still happen, but also a part of me wants to consider them as individual bills. So that, as we go through at least the subcommittee markup and the full committee markup, there will be ample opportunity for people's ideas to be heard.

Mr. Barton. Okay.

Mr. Burgess. I hope that satisfies your request for

information. And I will yield back.

Mr. Barton. Well, you used half of my time. Well, I think it is important to give the subcommittee and the stakeholders some idea of the potential plan. And I wasn't here yesterday. I was at the Zuckerberg hearing on Facebook. So, I am just asking for my own illumination.

One of the bills is a bill by Mr. Tonko, H.R. 4005. He has actually introduced it. He is ahead of the curve here, which is kind of normal for him. He is one of our more energetic Members.

But this particular bill, I wish he wasn't so energetic, actually, because it allows Medicaid programs to receive matching federal dollars for medical services to an incarcerated individual, which in Texas means somebody in jail for the 30-day period right before they are released. I have a real concern about that for a number of reasons.

So, I am going to ask Mr. Douglas if, under current law, the states couldn't ask CMS to use their 1115 waiver for a demonstration project to test this idea, instead of actually passing a federal statute.

Mr. Douglas. So, current federal law prohibits payment, Medicaid payment, for individuals who are in prison, except for the one exception relates to for inpatient settings when they leave the actual prison facility and go to an inpatient setting.

And that is clear in federal law. So, even under an 1115 waiver, that could not occur.

Now, that being said, there are creative alternatives. Centene, as a managed care plan, are working in Ohio, for example. Ohio is very concerned, given recidivism. The high rate of individuals within the prison system, as they transition, have needs of social services, medical care, behavioral health, to do early transition work as a responsibility, knowing that they are going to be assigned to a managed care plan, and the managed care plan is going to have increased costs if they don't work in the transition. And so, that is occurring right now in states. And other states are doing that. There are different creative approaches, but there is no ability from a payment standpoint right now under federal law.

Mr. Barton. Okay. Well, thank you for that answer.

In my one second that I don't have, I want Mr. Kravitz to talk about e-prescribing and if he thought that could help in some other areas, in addition to what has been done under his business.

And I am only asking this question because the chairman took two-and-a-half minutes of my time.

[Laughter.]

Mr. Kravitz. So, we feel at Geisinger e-prescribing is very valuable to our organization. It is very much a patient or

customer satisfier as well compared to the old process of a paper script that oftentimes was not available to them and would cause multiple visits to come back to a physician's office and able to get those.

What I can tell you is use of e-prescribing is very much endorsed by our physicians. The second-factor authentication is seamless, works very well. And that is why we are able to reduce the amount of time for prescribing an opioid prescription from 3 minutes to 30 seconds, because of the new process that we followed.

What I can also tell you is the first day -- and we, typically, at Geisinger don't do things small, unfortunately -- we did not do a proof-of-concept with a small group of physicians. We hit 1330 physicians day one to enroll them in the program, and we have other physicians that are requesting to be part of this process because it is so efficient and it has worked so well for them.

The other point that I made about the PDMP, we are clamoring to get the APIs or the integration points, so that we can do a lot more automation behind the scenes and not obstruct the workflow process or the physicians, so they could see more patients, to provide better quality care for more patients. That will be coming in the next three months, and we are very eager to have that happen, so that we can encourage that be part of

the process.

Mr. Barton. Thank you.

Thank you, Mr. Chairman, for your courtesy.

Mr. Burgess. The Chair thanks the gentleman.

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

Mr. Kennedy. Thank you, Mr. Chairman. Thank you for continuing the hearing.

Thank you to our witnesses for being here.

Mr. Botticelli, wonderful to be with you again. Thank you for your service and your outspokenness on these incredibly important issues.

I know we are here on a series of several dozen bills that are before this committee, which I hope many of them will see action, including, Mr. Chairman, our own. Thank you for putting that on the list.

I wanted to get your thoughts and members' of the panel thoughts on some of the broader priorities of this administration, recognizing that the administration has acknowledged that there is an opioid and behavioral health epidemic across this country. They have indicated that they want to prioritize it. Yet, we have also some policies come out of this White House that I was curious to get your thoughts on. I did have a chance to question our CMS witness yesterday. So, maybe just going right down the

list.

And, Mr. Botticelli, I was wondering, given your expertise on this issue, can you explain to me how cutting Medicaid by $800 billion, as the Trump administration budget does, is effective in addressing behavioral health and addiction?

Mr. Botticelli. First of all, thank you, Congressman, for the question and for your leadership not only here, but in Massachusetts.

I think we have broadly acknowledged that this is a public health crisis that we have and we have got to focus these issues largely on health responses to this issue. Tantamount to that response is making sure that people have adequate access to insurance and coverage. And when you ask historic data, when you look at why people can't get treatment, the No. 1 reason why people can't get treatment is because they don't have adequate access to insurance.

Mr. Kennedy. And so, does cutting $800 billion from Medicaid help or hurt?

Mr. Botticelli. It hurts, and it hurts dramatically.

Mr. Kennedy. And I am sorry to cut you off; I just want to get everybody else on the record.

Mr. Douglas, how would you respond to that? And be quick, just because I have got a couple of more of these.

Mr. Douglas. Yes. No, I am going to turn this around.

As you know, as a former Medicaid director and as a managed care, our responsibility is how to use the resources most effectively as possible. And so, the idea of cutting $800 billion, there are ways to achieve savings, but it has to be rational.

Mr. Kennedy. So, does a $800 billion cut help or hurt an administration's ability to --

Mr. Douglas. I can't answer without understanding what the flexibilities and the ability to provide the right services and the right setting.

Mr. Kennedy. And, Mr. Guth?

Mr. Guth. Yes, so this is a complex situation we are dealing with. This really goes back to the first question we had before this panel. And that is about the disparity in presentation with Medicaid and with private insurance. For a long time, people with private insurance didn't have access to substance use treatment, or very limited access. Most of the people I know that went through private insurance with these issues ended up spending college funds and retirement funds, in order to get care.

Mr. Kennedy. So, Mr. Guth, would you support greater enforcement of mental health parity?

Mr. Guth. I think we have got to do everything we can right now, Congressman, to ensure that people have access to care. And for the majority of Americans, that means access through some form of third-party coverage, and for many of them, that means

either Medicaid or some other form of federal funding.

Mr. Kennedy. Mr. Kravitz?

Mr. Kravitz. I would say at Geisinger Health System we treat all patients equally. Eighteen percent of our patient population in our provider network are medical assistance patients; 44 percent are Medicare. We have a number of programs, and there are care management programs that address this. It would be my impression that it would hurt.

Mr. Kennedy. Sir?

Mr. Srivastava. From Magellan's perspective, we fundamentally believe that health care needs to be not just below the neck, but above the neck. And so, it is a full whole patient approach. And so, to the extent we have adequacy of funding, to be able to have behavioral health, improve access for behavioral and physical health issues, then we are a proponent of that.

Mr. Kennedy. I have got about a minute and a half left and two more issues I want to address with the panel. So, Mr. Botticelli, I will address them both to you, and just go down the line.

Given your expertise, how long does it take for somebody to recover from a mental/behavioral illness?

Mr. Botticelli. So, this is a chronic disorder, and one could argue that it is a lifelong issue. The biggest predictor

of success is duration and time in treatment.

Mr. Kennedy. And so, two policies put forth by this administration, lifetime caps and work requirements, if you think work requirements could, in fact, be helpful to people suffering from mental/behavioral illness, I would ask anybody on the panel to point me to one single study that says so. So, your opinion on those two, lifetime caps and work requirements, coming from this administration?

Mr. Botticelli. So, lifetime caps seem to me to be a violation of parity because I think that we understand that that has been an historic discriminatory tool that insurance companies have implemented to not treat this as a chronic disease and give people long-term care.

Mr. Kennedy. Okay. And work requirements?

Mr. Botticelli. So, one, we know people on Medicaid generally now are working, and often working more than one job. And I think the ultimate goal of treatment, quite honestly, is to get people and restore them.

Mr. Kennedy. Is there any study that you are aware of that says a work requirement increases health, understanding that people who are working can be healthier, but that causation goes the other direction?

Mr. Botticelli. I have nothing.

Mr. Kennedy. Mr. Douglas?

Mr. Douglas. I don't know of studies on that. What I say is that this gets to the issue of underlying social determinants and making sure from states, as well as Medicaid organizations, Medicaid managed care plans, that we are working on how to engage people into ensuring they are getting both the right social and getting back into the workforce.

Mr. Kennedy. Mr. Guth?

Mr. Guth. Yes. So, we were working with two of our states that have these, are implementing work requirements, and the devil is in the detail because what you don't want to do is insist that somebody who is very, very sick get a job before they can have access to treatment. On the other hand, the plans that we are working with in the two states that we work with, Indiana and Kentucky, we are seeing administration -- understanding that and making sure that we are not asking people who are actively sick to become employed before they become stable. So, I think it is all about the implementation.

Mr. Kennedy. The CMS witness yesterday said they are trying to put patients before paperwork. Is there a work requirement initiative out there that does, in fact, lead to less administrative burden for somebody that is suffering from mental/behavioral illness to make sure that they stay on Medicaid?

Mr. Guth. Can you ask that question again? Mr. Douglas. What I would say is that what we are seeing in Indiana as well

as in Arkansas, there are exceptions for certain populations such as those with substance use disorders.

Mr. Kennedy. I am about a minute over time. Thank you for your generosity, Mr. Chairman.

Mr. Burgess. That is all right. I have subtracted it from Mr. Latta's time.

Mr. Green. Mr. Chairman, I ask unanimous consent --

Mr. Burgess. Oh, I beg your pardon. Does the gentleman have a unanimous consent request?

Mr. Green. The gentleman does. I ask unanimous consent that a letter from the telehealth and technology stakeholders and a letter from treatment providers in support of the access to telehealth services for their opioid and use disorders, I ask unanimous consent to place it in the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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

Mr. Burgess. The gentleman from Ohio is recognized for 5 minutes for your questions, please, Mr. Latta.

Mr. Latta. Thank you very much, Mr. Chairman. And thanks again for holding this hearing today, because, again, combating this opioid epidemic is something we are all in and we have to do, because we are looking at these very sobering statistics that 115 Americans are dying every day in the State of Ohio. And I hate to keep repeating these statistics, but in 2015 we lost 3,050 people. In 2016, that number went up to 4,050. And then, the fiscal year ending at June 30th of last year, it was 5,232. So, it is an epidemic that we have got to take on and fight.

And I appreciate you all being here today.

Last week I held a roundtable in my district with local pharmacists to discuss the opioid crisis in Ohio. Most of the pharmacists agreed that prescription limits would help prevent addiction. Overprescribing of opioids for acute episodes of care can have dire consequences as pills can be diverted, misused, and perpetuate addiction.

In response to this problem, over 20 states, including Ohio, have adopted laws limiting the number of pills that a patient new to therapy prescribed an opioid for an acute episode can receive. These laws reflect guidelines promulgated by CDC which note that, for the vast majority of acute procedures, three to seven days' worth of therapy is sufficient. They also respect

the judgment of the prescribing practitioner by providing for exceptions if a prescriber thinks in his or her best judgment that a longer duration of treatment is medically necessary.

Furthermore, we recently saw CMS finalize a similar policy for beneficiaries and wrote in Medicare Part D, driving home the severity of the problem and the belief that such rules will have a measured impact on opioid diversion and misuse.

Mr. Douglas, what impact would expanding this type of policy beyond Medicare have on the diversion and misuse of opioids?

Mr. Douglas. As I noted in my written testimony as well as earlier, we are doing a lot within Centene, as well as a lot of states are working on making sure that we are reducing the limits on duration as well as refills. And so, creating clear policies on that, where we have been able to do that and work with the state, it helps on overprescribing as well as reduced inappropriate utilization. And so, this is an important area that we are seeing. In many states we can work and partner with our state agencies and be able to put in place those types of utilization controls. But incenting states and incenting managed care organizations, that is an important part of the overall continuum of how we need to prevent this epidemic.

Mr. Latta. Thank you.

Mr. Guth, my district ranges from densely populated cities and towns to very rural areas. And we all know that the opioid

epidemic knows no boundaries. Therefore, health access in rural America is vital, especially as it relates to the opioid epidemic. It is hard enough for individuals to make the decision to overcome addiction without the added barriers to access to treatment due to their location.

Would you go into some detail about the barriers are out there for opioid treatment for individuals in rural communities and what they face, and how we have to address those issues?

Mr. Guth. Thank you. Yes, Congressman. There are several issues that jump out. One is that we have a shortage nationwide of professionals who are certified and trained in addiction services. So, that permeates the whole country, and it is most acutely felt in our rural areas.

Centerstone, most of the communities we serve are very small rural communities across the five states that we serve. So, we are very attuned to this issue.

Telemedicine can make a huge difference. There are current challenges with telemedicine, but we have been involved with telemedicine services since the early '90s. And we would wheel in these great big, giant monitors on these enormous carts. That was really to address the issue of access to care in our rural areas. In many cases it was the first time we could get a child psychiatrist into some of these communities, the very first time.

So, this issue is true with opioid use as well. We have

to be able to provide expert care into our rural communities, but we have to address the overall shortage of practitioners nationwide in order to do that.

The other is we have to also recognize that there are other specialists involved in this care that are very important. Mr. Douglas mentioned peer support services. Those are critical, and we find that those services, if we can get them funded, which is very spotty, if we can get those services funded, we can provide some really vital linkages in our rural communities. We generally can have access to those individuals.

So, telemedicine, you know, we are using apps right now to help people be connected remotely from their service provider. But when somebody is dealing with an acute psychiatric disorder or an acute addiction challenge, asking them from a rural community to drive hours into an urban area to seek service is really an insurmountable barrier for most of them. And what they will do is they will end up in the emergency room in a really critical state.

So, those are all issues that I think we would need to address. Technology plays a role. Workforce improvements play a role. And the other is we really do need to be advancing the use of peer specialists. And we found peer specialists -- we have got the data -- peer specialists make a huge difference in the continuum of care.

Mr. Latta. Thank you very much. Mr. Chairman, my time has expired and I yield back.

Mr. Burgess. The gentleman is correct, his time has expired.

Does the gentlelady from Florida wish to be recognized?

Ms. Castor. Yes, sir.

Mr. Burgess. The gentlelady from Florida is recognized, 5 minutes for questions, please.

Ms. Castor. Well, thank you, Mr. Chairman.

And thank you to all the witnesses. I have been monitoring this hearing from another E&C hearing, and I am heartened by the discussion and the commitment, particularly relating to Medicaid and Medicare, and how we have to strengthen and modernize Medicaid to tackle all these challenges that we face, particularly opioids.

And I noted some of the discussion, coming from Florida, on the difference in treatment between expansion states and non-expansion states. We have hundreds of thousands, if not millions, of Floridians who really would benefit with consistent treatment, if we had expanded Medicaid. So, I know that is going to continue to be an issue.

A lot of these bipartisan bills are very positive, in my opinion, and I have heard what you have said about a number of them. But I don't think we are yet at the scale we need to really tackle the problem. I have heard others talk about a Ryan White

type of commitment, something that is dependable and consistent moving forward that aren't relying on the budget battles of the Congress, so that providers and law enforcement, everyone across the board can really tackle the problem the way we need to.

Does anyone have a comment on that and about creating more of a Ryan White type of consistent commitment?

Mr. Kravitz. I will just mention this: I think when we look at the financial crisis, one of the things that our medical director points out is that a huge amount of the resources we are spending, we are spending on people that are returning for care. They are returning for care because they didn't get proper care to begin with. And we also look at the cost that we are spending in emergency rooms and acute care hospitalizations for folks that have untreated or undertreated substance use disorders or psychiatric disorders.

And I appreciate the breadth of bills that are before this committee and the work that everybody here has done on this crisis. But I think this is a huge call to action for all of us. And it is not just about doing more of what we are doing. We have to change.

I want you to think about this. I represent one of the largest nonprofit providers in this space nationwide, and we are saying to you we need more regulation in this field; we need to be held to a higher standard; we need to be accountable for

outcomes, and we also need to be accountable for providing a full continuum of care, so that people get the care they need, not the one specialty service that a provider has found a business model to support.

So, long answer to your question. Absolutely, it should be a huge call to action. We can't let this epidemic continue to rage across this country. This is a complex problem. It didn't happen overnight. You heard the talk today about the different presentations, why people get into addiction to begin with, whether it is because of unmanaged pain or because of a co-occurring psychiatric disorder. There are lots of reasons for it. This is not a simple solution. But I would say a big focus needs to be on we have got to quit doing things that don't work, and also understanding that the investment we make here will be more than realized with the savings in other areas, not even just the social impact of these issues, but in the medical costs in other areas of health care.

Ms. Castor. Thank you.

Mr. Kravitz. I hope that answers your question, Congressman.

Ms. Castor. Yes, and I have one more question, but if somebody wants to add quickly -- yes, sir?

Mr. Botticelli. For many years I presided over the treatment system in Massachusetts. I think if you talk to many

providers, while grant funding is great, having a stable insurance-based program really ensures that we are going to have -- we have been talking about provider workforce here and how critical it is. So, I think we need to make sure that we particularly ensure Medicaid coverage for people with substance use disorders. I think grants are great, but providers, I think, are often reluctant to get into this business --

Ms. Castor. Yes.

Mr. Botticelli. -- and stay in this business without a stable insurance base from which to build.

Mr. Douglas. And if I could just say that, from both a state as well as an MCO, the idea of, well, Ryan White is really a trusted and needs to be an integrated approach. And so, looking at this through the lens of not creating a siloed solution, but how it integrates into the continuum of health and behavioral health.

Ms. Castor. Yes. Thank you.

Mr. Srivastava, in your testimony you mentioned that the number of physicians that prescribe MAT pales in comparison to providers able to prescribe oxycodone. And SAMHSA estimates over 48,000 providers currently certified to prescribe MAT versus 900,000 providers prescribing oxycodone. The lack of providers is undoubtedly more extreme in areas with a high proportion of Medicaid beneficiaries or in rural areas. How can we both increase the capacity to prescribe evidence-based treatment like

MAT and realize the benefits? Could you expand specifically on the key lessons Magellan learned working in Pennsylvania and how that could be expanded elsewhere?

Mr. Srivastava. Absolutely. So, in Pennsylvania, for example, we recently launched, in partnership with the governor, we provide county-based behavioral health services. And so, we have created 20 centers of excellence which look at both primary care coupled with behavioral health care in an integrated fashion, connected by telehealth, and all evidence-based. And it allows for substance use disorder to be kind of effectively treated and managed. We also partner with Geisinger as well on some behavioral health --

Ms. Castor. And you had a specific recommendation on a temporary FMAP increase?

Mr. Srivastava. Correct. So, roughly, about 900,000 doctors today are licensed to be able to prescribe. Only 48,000 can prescribe MAT services. So, there is a need to be able to, one, educate more providers and, two, to be able to potentially offer a pay bump, if you will, in order to incent those providers to take eight hours out of their day to get certification and, then, training wrapped around that as well. And so, our sense is that there should be funding set aside to be able to drive more certifications, so that providers know how to prescribe medication-assisted therapy. We would augment that with

tele-behavioral health, digital therapy, text therapy, and coupled with peer supports and care coordination.

Ms. Castor. Thank you. I will yield back.

Mr. Carter. [presiding] The gentlelady has yielded.

The Chair recognizes the chairman of the full committee, the gentleman from Oregon, the Honorable Mr. Walden.

The Chairman. Thank you. Thank you, Mr. Carter. I appreciate it.

And thanks to all our witnesses. Sorry I wasn't here at the beginning. We have a concurrent hearing going on with the Secretary of Energy on energy-related issues before the committee. But we really appreciate your participation.

So, I have a couple of questions I wanted to make sure and get in this morning. I think we all recognize the importance of ensuring that patients in Medicaid with substance use disorder have access to a continuum of care. One of the bills before the committee is a targeted proposal that would remove a barrier to care and allow care in an IMD for up to 90 days in a 12-month period. Now this allows for longer treatment periods for all beneficiaries, not just selected subpopulations. And we believe this is budgetarily responsible as well. Virtually every stakeholder group that I have met with suggests that some of the IMD exclusions should be repealed or at least recalibrated, since residential treatment may be needed for some beneficiaries with

substance use disorder.

So, my question for each of you is, do you agree that the bill before the committee which offers a partial repeal of IMD is a helpful step to ensuring that Medicaid beneficiaries receive the care that they need? So, do you think this makes sense? We will start with you.

Mr. Botticelli. Chairman Walden, I think while we are trying to do everything that we can to expand access to treatment, and particularly looking at Medicaid, I think just looking at the categorical waivering of IMD requirements, quite honestly, I think has a potential to exacerbate our problem.

The Chairman. Why is that?

Mr. Botticelli. Well, one, I think we want to ensure, and I think CMS's approach to looking at this issue through the 1115 waiver I think makes a lot of sense. Because what they have been saying to states is you need to demonstrate to us that you are not just providing residential and often expensive levels of care, but that you have a full continuum of care, outpatient services, medication-assisted treatment.

The other piece, too, and I think we have seen this and we are all talking about increasing access to medication-assisted treatment, but the reality is that only about 20 percent of our programs now provide access to medication-assisted treatment. And so, I worry that we are, in our efforts and, then, I think

our good intents to expand access to treatment, we are focusing not necessarily on the most effective treatment needed for people with substance use disorders --

The Chairman. All right.

Mr. Botticelli. -- which is often outpatient care.

The Chairman. Mr. Douglas?

Mr. Douglas. So, I agree with a lot of what Mr. Botticelli said, but I would say the waiver process is still cumbersome. I have gone through it from California, seen it in other states. The regulation on the managed care side doesn't go far enough.

That being said, so the idea of eliminating the IMD rule on substance use is very important from an MCO, and states support it, but it does -- it does -- need to be part of an overall continuum. It can't be siloed because there are many cases where residential is not appropriate. We need to ensure that we are using ASAM evidence criteria and other treatment modalities within that and creating the right incentives --

The Chairman. Right.

Mr. Douglas. -- that there is in a continuum.

The Chairman. All right. Mr. Guth?

Mr. Guth. So, I'm just going to reiterate very quickly some of the same things you have heard. We think it does need to be expanded. But I think, absolutely, we must have requirements on continuum of care, accountability around outcome, really

criteria that places people in the right level of care. What we are all worried about -- and I know this is the issue around this bill -- is that, suddenly, we are going to have this plethora of very expensive care that is now just exploding across the country.

The Chairman. Right.

Mr. Guth. The answer to that is to ensure that when these expansions are permitted, that they are coupled with requirements around continuum of care and documented evidence that people are placed in the least restrictive care appropriate to their presentation. That is known. We can do that, but we don't do it in isolation. Like everything else we have talked about today, these are complex issues. So, we have to have solutions that have the complexity associated with them.

The Chairman. All right. Thank you.

Mr. Kravitz?

Mr. Kravitz. We are very much affiliated with continuum of care. And so, we just launched a new program last week, and it's called Geisinger at Home, where a physician actually goes into the patient's home. It sounds like old times, but that is the way it is going in the future. And so, the technician supports all of that. It is based upon chronic diseased patients. These are the same types of patients that we will be treating in the home setting with telemedicine and other opportunities, as well

as documentation and electronic feeds right into our electronic health record.

The Chairman. Okay.

Mr. Srivastava. In short, although we have the 1115 waiver process, supportive of an overall process. However, it is just one kind of solution in a suite of solutions. So, I don't want to overprescribe the fact of the value created with this. It could create capacity, but at a cost that may not be sustainable.

The Chairman. All right. My time has expired again. Thank you all for your testimony and your answers to that question and others today.

I yield back.

Mr. Carter. The gentleman yields.

The Chair recognizes the gentleman from Florida, Mr. Bilirakis, for 5 minutes.

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

And I wanted to thank Mr. Botticelli for coming down to my district in the Tampa Bay area when he was the drug czar about a couple of years ago. It was very informative, the forum we had. So, I appreciate it very much.

Also, I want to talk about and I want to ask some question on the lock-in. I know we have covered it a little bit, but I have a couple of bills with regard to that. So, I want to start with Mr. Douglas, if that is okay.

Yesterday CMS talked about the importance of lock-in as a tool to manage prescription drug abuse in Medicare Advantage and Medicare Part D. Lock-in is not new and has been used for years in Medicaid and commercial insurance. Since you run a Medicaid managed care plan, you might be able to talk about how lock-in programs operate and what you have seen.

Does your plan run a Medicaid lock-in program and, if so, can you tell me how you structure the program and what triggers you are looking for in identifying an at-risk beneficiary, please? Thank you.

Mr. Douglas. So, yes, as you said, lock-in programs have been around for a long time, both from a state agency as well as from managed care programs. And Centene, in our states we have over 10 states where we do have lock-in programs. We work in partnership with the Medicaid agency to structure and be able to create the policies and procedures. There is no, I would say, one-size-fits-all approach to lock-in programs. In some states, the lock-in is around the prescriber; in other cases, it is about lock into a pharmacy. Or, it could be both prescriber and pharmacy being locked in and having the member have one prescriber and one pharmacy. So, it varies.

Now there are triggers in terms of the types of utilization, looking at how, for example, in one criteria I will go through they are looking at using three or four pharmacies within a 30-day

period. Three or more prescribers within a 30-day period become triggers, utilizing five or more controlled substances in a 30-day period, different drug classes. So, we look at all different types of triggers and create that policy.

In many cases, the pharmacy board is part of the process, too, to make sure that they are integrated into the policy development along with the Medicaid agency. We, then, also, before we do the lock-in, there are notices sent out to members, notices sent out to prescribers and the pharmacies. So, everyone is onboard and understands the new process that is in place.

We have found this to be very effective. Again, you need to cast the net appropriately, and that is where having the right triggers and knowing who that you are bringing into the program, so you are not inappropriately restricting access to needed services. But, where done, we have some evidence and data that has shown that we have been able to bend the cost curve and be able to still provide the right outcomes in these lock-in programs.

Mr. Bilirakis. Mr. Srivastava, do you want to elaborate? I know you answered that question when Mr. Guthrie asked you that question. But do you want to elaborate as to the triggers?

Mr. Srivastava. Sure.

Mr. Bilirakis. And how do you identify the at-risk beneficiaries?

Mr. Srivastava. Absolutely. Just to add on what I said previously, we operate two plans, in Florida and in Massachusetts today where we have a lock-in place on Medicaid. And we see kind of expanding that into Medicare Advantage in 2019.

Really, it is a community-based outreach effort to do lock-in effectively. So, it is engaging with the individual. Each state has different criteria as it relates to Medicaid. And so, we are kind of following the state's guidelines and trying to be coordinated. But it is coordinating with the individual and coordinating with primary care as well as specialty care. In a lot of these cases, these are individuals with physical health as well as comorbid behavioral health issues. And so, as a result, we are working with community-based mental health centers as well to be able to have a coordinated approach towards a lock-in related to a prescriber at a location, so that we can kind of reduce overuse or misuse of drugs.

But I think another key element is simply making sure that we have care management wrapped around that, as well as in-home services, peer supports, and access to tele-behavioral health and telehealth services as well, to make sure there is a coordination of care.

Mr. Bilirakis. How effective has the program been?

Mr. Srivastava. So, we have seen it has been effective in Florida, from our perspective, in your area, and we have been

able to see kind of reduced utilization and stability in terms of outcomes. So, the recidivism or kind of admissions and readmissions related to things have gone down.

Mr. Bilirakis. Mr. Douglas, how effective has the program been?

Mr. Douglas. Again, very effective, that we have seen a reduction in costs, overutilization, primarily from pharmacy spend, but also on the medical side as well from inpatient as well as emergency room. So, when done right, it has been very effective.

Mr. Bilirakis. Okay. Very good.

I will yield back, Mr. Chairman. Appreciate it.

Mr. Carter. The gentleman yields.

The Chair recognizes the gentleman from Indiana, Dr. Bucshon.

Mr. Bucshon. Thank you, Mr. Chairman.

Mr. Kravitz, prior to becoming a Member of Congress, I was cardiovascular and thoracic surgeon. As a physician, I believe that in order to properly address some part of the opioid crisis, we need to address the causes, one of which is how we diagnose and manage chronic pain. From your experience as a system, what is the most effective way for providers to engage patients about pain and pain management?

Mr. Kravitz. So, I have a personal situation. My wife

today had a pain management visit due to an injury to her neck.

Mr. Bucshon. Yes, particularly new patients and seniors also?

Mr. Kravitz. Okay. So, she is a new patient, and seniors, the same way. Our prescribers and our specialty physicians -- and I attended the visit with her to see a neurologist -- they take the opportunity to counsel and discuss, to review what actually the injury is for that particular patient. Again, firsthand, I saw where opioids were not even introduced. That was discussed as not being an option in this case. Other methods with regard to physical therapy, behavioral therapy, things of that nature, in this case it is physical therapy, which will begin immediately. Injections and things like that which are non-opioid type of medications.

But we take the initiatives to work with the patients, the same as with our Medicaid or Medicare population patients. We would much prefer not to go down the path of opioids because of the risk associated with opioids. And so, I think that has been our process, and I have seen it firsthand.

Mr. Bucshon. I mean, the gist of it is it is critical to have the good evaluation of the causes of pain --

Mr. Kravitz. Absolutely.

Mr. Bucshon. -- and, also, proper counseling with the patient and family about alternative treatment? I will speak

for the physicians. I am a physician. Historically, I think maybe we haven't done that as well as a society as maybe we could have, right?

Mr. Kravitz. I think being part of a physician-led organization like Geisinger, and known for the innovation that our physicians lead and our technology supports, that has been our mantra, so to speak, that that is the direction we want to go. Is it a perfect organization? No, far from it, but we will continue to iterate and make it better and tighter as time goes by.

Mr. Bucshon. Yes, and it is also pretty clear that it is important for care providers to have a complete understanding of not only the current pain problem, but their pain history.

CMS testified yesterday and it was mentioned that the way we look at pain needs to evolve from just treating the pain to a full conversation about pain management, and I think you would agree with that.

Mr. Kravitz. Yes, absolutely.

Mr. Bucshon. So, we had that yesterday.

Mr. Srivastava. Congressman, if I could just add?

Mr. Bucshon. Yes.

Mr. Srivastava. At Magellan -- Geisinger is a vertically-integrated system that has complete access to data and a strong delivery model -- we were on a network model. So,

we serve about 7.5 million people today with chronic pain management services where we partner with health plans and partner with providers.

I think the key there is having strong data and analytics and offering up alternative therapies, as you outlined. The one piece that I will just add is that the alternative therapies wrapped around virtual care delivery is really a first-line therapy for us. So, how can you manage pain with cognitive-based therapy? Second, then, with telehealth or tele-behavioral health as well, text therapy as well, in order to kind of augment. So, there is a level of that compounded with home care services that could also alleviate pain beyond just opioid use.

Mr. Bucshon. Yes. And again, for you, Mr. Srivastava, in your testimony you suggested that any willing provider requirements are problematic for health plans due to the behavior of some rogue pharmacies who engage in fraud. I would like to try to get a better understanding for that because I have a little bit of a skeptical view on that. It is my understanding that fraudulent behavior from a pharmacy is prosecuted by CMS and other state authorities. Is the concern that managed care plans have to take any pharmacy willing to accept the plan's contract and maybe they don't want to do that? Or, is the concern that pharmacies with problematic business patterns are not identified and pursued quickly enough?

Mr. Srivastava. It does not have to do with kind of building a network and accessing discounts. It has everything to do with having a quality network where things are credentialed and there is high-quality delivery. And if there is kind of aberrant behavior, things that are outside the norm, that we should be able to not have to be required to contract with that entity. And we are not speaking to the majority or a large portion, but a very small portion.

Mr. Bucshon. Okay, yes, because, I mean, from my standpoint also not only as a Member of Congress, but as a physician, it is important for me to ensure that our Medicaid or Medicare patients have access to high-quality providers and pharmacies, and that situation not to be restricted in a way that makes it difficult for people to access their pharmacies.

Mr. Srivastava. It is all about the quality --

Mr. Bucshon. Yes.

Mr. Srivastava. -- and making sure there is a level there. Thank you.

Mr. Bucshon. Fair enough. Thank you.

I yield back, Mr. Chairman.

Mr. Carter. The gentleman yields.

The Chair recognizes the gentlelady from Indiana, Ms. Brooks.

Mrs. Brooks. Thank you, Mr. Chairman.

Mr. Douglas, in your testimony you mentioned the importance -- and a few of you did as well, and so, I would like to hear more from others -- but you mentioned specifically the importance of provider education as one way to reduce opioid use and abuse, and including educating providers about the risks of high-dose prescribing and best practices in the treatment of pain and addiction risk associated with prescribing opioids for pain. I would like to hear a little bit more about the outcomes that you have seen, and others have seen, about provider education policies and whether or not it has led to a reduction in opioids prescriptions, and whether, with those outcomes and since you have implemented policies like this for your providers, how has it impacted the numbers of patients actually using opioids? And has there been a noticeable decrease in patients seeking treatment for their addiction? A lot of different --

Mr. Douglas. Yes, a great question.

What I would say, first of all, I have seen directly from Centene that, for example, we offer free continuing medical education as one way to make sure on alternatives -- we have talked about alternative therapies and treatment and better ways of pain management. Too, there are different projects -- ECHO is going on -- as ways to do this. And then, there is also, through 1115 waivers, a lot of work going on where you see collaborative models of the best and evidence-based approaches on pain management.

What I would say in terms of outcomes is the hard thing to pinpoint on education is this is a continuum of prevention approaches, from what is going on out front, and we have talked about everything from very, very aggressive approaches around lock-in to really limiting prescription refills, to the length. So, we from Centene, and I have put it in my write-up, have seen reductions, significant reductions, in overall numbers. That being said, I can't tell you it is just about education. It is about the comprehensive nature and approach, that you need to create the right incentives for states and Medicaid managed care organizations to be looking comprehensively and not just thinking education is going to solve it, but around all of the different approaches.

Mrs. Brooks. Oh, certainly. No, there is no question that it needs to have a lot of different approaches.

Have your prescribers complained about prescriber education?

Mr. Douglas. I would have to get back to you on it. I think this gets to a broader issue, and this is where you need to create the right investment. It is our providers, you know, we ask a lot of our providers. And so, we try to create the right platforms -- and this gets to how, for example, CME, they already need to do it -- ways that we are not just adding another additional burden without any payment. And so, it has got to be the balance between

creating the right incentives and the right venues and right financing to ensure we are getting the high-performing providers who are paid adequately to provide the right access and the right types of treatment.

Mrs. Brooks. Thank you.

You brought up provider education, Mr. Botticelli. Can you expand on either Mr. Douglas' points or any additional of your own --

Mr. Botticelli. Sure.

Mrs. Brooks. -- with respect to prescriber education? And prescribers meaning physicians, nurse practitioners, dentists, everyone.

Mr. Botticelli. One of the issues that we saw driving overprescribing was, quite honestly, misleading information. As you talk to many prescribers, they will tell you that they were kind of trained that these were not addictive drugs, that these should be prescribed liberally. And while I agree with Mr. Douglas that you can't kind of pinpoint to one specific thing, I think it makes intuitive sense to give providers good, fact-based education as it relates to this issue.

Again, while I do think we need to provide incentives, and I say this not to overexaggerate, but while we have seen some modest declines in prescribing, we are still prescribing at three times the level that we were in 1999. And I don't think it is

unreasonable to ask a physician, kind of 15 years into this epidemic, to take some modicum of continuing medical education, either on safe prescribing or just on substance use issues in general.

Mrs. Brooks. Thank you.

Mr. Kravitz, or any of the others, comments?

Mr. Kravitz. Yes, I would love to comment on that. So, I had mentioned in my testimony we have a provider dashboard. So, that tracks providers that are high prescribers for opioids. We use that as part of our continuous monitoring for our physicians who we have educated and trained on this. We will continuously go back and address issues if we still see a persistent level of prescriptions being prescribed -- overusing that term -- but by these particular providers. And they could be nurse practitioners, physician assistants, anyone who has a DEA license number in this case. So, we address it. We are very much concerned about the quality of care delivered to our patients, and that is one of the areas where we focus on very heavily with analytics.

Mrs. Brooks. Thank you.

I am out of time. I yield back. Thank you.

Mr. Carter. The gentlelady yields.

The Chair now will recognize the gentleman from New York, Mr. Tonko, for 5 minutes.

Mr. Tonko. Thank you, Mr. Chair.

I don't see Mr. Barton in the room, but I do want to address my colleague's concerns and I appreciate his kind comments. But I want to make it abundantly clear, my bill does not expand Medicaid eligibility in any way. It simply would allow states the flexibility to provide for existing Medicaid beneficiaries who are returning into the community in less than a month.

Vast bodies of evidence confirm that individuals engaged in addiction treatment have lower rates of recidivism and lower healthcare costs, and we have undone many, many situations where they would have overdosed and died. That is what my bill does, straightforward. It is about being smart on crime and effective for the taxpayer.

In trying to address the opioid epidemic, one of the populations I have the greatest concerns about is individuals who have had involvement with the criminal justice system. As I mentioned during the first panel, for individuals reentering society after a stay in jail or prison, the risk of overdose is as high as 129 times that of the general population during the first two weeks of post-release.

In states that have specifically collected data on this population, such as Rhode Island, we have seen that justice-involved individuals can account for at least 15 percent of the total overdose deaths. If we extrapolated that figure

nationwide, we are talking about 10,000 deaths a year among individuals less than a year removed from correctional settings.

Mr. Botticelli, let me welcome you back to this committee and direct the question your way. Drawing on your previous role at ONDCP or your current position at BMC, what are some of the unique challenges that this justice-involved population faces in accessing effective addiction treatment, and how can we do a better job of meeting the needs of this population?

Mr. Botticelli. Thank you for the opportunity to address you again.

Our data in Massachusetts underscores some data that you've already said, and we see people who are coming out of our jails and prisons overdose and die at one-hundred and twenty times the rate of the general population. And while we've made success with many populations, that is one area where we need to have concern.

And I will tell you that, very interesting, Boston Medical Center is right across from the Suffolk County Jail, and we actually try to make sure that we are getting people as they come out of prison into our services. But it often can be challenging. And even though we do a good job of trying to get people on insurance, being able to have that seamless coverage, actually start people on treatment while they are in jail becomes important.

And the last point that I will make is we have a significant number of sheriffs in Massachusetts who operate county houses of correction, who I think would have greater uptake of medication-assisted treatment while people are in jail. But part of the predicament that they run into is cost. To your point, with already Medicaid-eligible folks, if we have some modicum of transition services to be able to make sure that folks have that seamless bridge back to the community, that, to your point, not only can we reduce overdose deaths, but we would reduce costs and we would reduce recidivism.

Mr. Tonko. That is a smarter use of the taxpayer dollar.

Mr. Botticelli. It is.

Mr. Tonko. Thank you, Mr. Botticelli.

In an attempt to address some of the challenges you spoke about, I introduced the Medicaid Reentry Act, which would provide states with new flexibility to draw federal matching funds for care provided to Medicaid-eligible, already Medicaid-eligible incarcerated individuals in the 30-day period prior to release, rather than waiting until the day of release itself.

Mr. Douglas, as a former state Medicaid director, would this type of increased flexibility have been useful to you as you crafted a response to the opioid epidemic?

Mr. Douglas. Absolutely. What we see, we have innovative programs now. I can see, and I mentioned earlier, in Ohio, where

there is a lot of work going on between the correctional system and the managed care organizations where there is a pre-release program in place, that we do a lot of work.

Mr. Tonko. I am going to cut you short because I only have about 35 seconds left.

Mr. Douglas. Okay, fine.

Mr. Tonko. But I appreciate it.

Mr. Douglas. Yes.

Mr. Tonko. For the rest of the panel, do you agree that initiating addiction treatment and care coordination services for reentering Medicaid beneficiaries before they leave a correction setting would improve their health outcomes, including overdose deaths for these individuals upon reentry, yes or no?

Mr. Kravitz. Yes.

Mr. Douglas. Yes, sir.

Mr. Guth. Yes.

Mr. Srivastava. We have experience in three states. Yes.

Mr. Tonko. Okay. Mr. Douglas, coming back to you, your company has done some innovative work in the reentry space with subsidiary Buckeye Health Plan, a Medicaid managed care organization operating in Ohio. Buckeye participates in Ohio's Medicaid Pre-Release Enrollment Program under which managed care organizations provide care coordination services through videoconferencing to certain high-risk incarcerated individuals

prior to release from prison. Beneficiaries are provided an insurance card and a care plan the moment they walk out of a corrections facility.

I was hoping you could briefly describe Buckeye's participation in this program and share any data that you believe are significant for the previously-incarcerated beneficiaries who have enrolled with Buckeye.

Mr. Douglas. Yes, and I am happy afterwards to provide for the record -- we have a flyer that gives more detail on this -- knowing that we are out of time.

But, just in a nutshell, we work 90 to 120 days before release getting them, making sure they are going to be enrolled in Medicaid, so that they are actually Medicaid-eligible. We develop a transition plan. We, through a videoconference, review that with their care manager. We schedule post-release appointments. Then, we make sure that pre-release that they are getting a 30-day supply of medicine, especially for those with behavioral health needs. And then, we do a care outreach five days after release to make sure they are connected to both integrated behavioral health services as well as social services. Across not just with Buckeye, our plan, but all of Ohio has had 20,000 former inmates enrolled in this program.

Mr. Tonko. Thank you, Mr. Douglas.

Finally, I will just state -- and I know my time is out --

but I will state that, if with this human health crisis, this opioid epidemic, our goal is to save lives, I challenge this committee to say no to addressing those who are incarcerated. It should not be a caste system here. Many people find themselves incarcerated because of this illness, and we need to be compassionate and I think effective with the taxpayers' dollars.

With that, I yield back, Mr. Chair.

Mr. Carter. The gentleman yields.

The Chair now will recognize himself for 5 minutes.

I would like to ask unanimous consent to submit two letters for the record supporting the Pharmacy and Medically Underserved Areas Enhancement Act. Without objection.

[The information follows:]

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

Mr. Carter. Mr. Guth, I am going to start with you. I wanted to ask you, the recommendations that have been put forth by the President's Commission on Combating Drug Addiction and the Opioid Crisis stated that, "There is a great need to ensure that healthcare providers are screening for SUDs and know how to appropriately counsel or refer to a patient." It would appear to me that this is an opportunity for Congress to direct CMS that CPT codes be expanded or added to, and that we identify patients at risk for opioid use disorders.

Mr. Guth. Absolutely.

Mr. Carter. Would you agree with that?

Mr. Guth. Absolutely.

Mr. Carter. Should we be looking at creating or amending CPT codes? As I understand it, it is done in other areas. In fact, it is done for chronic care with alcohol and substance abuse, and other areas as well.

Mr. Guth. Absolutely. I am very much supportive of that.

Mr. Carter. Okay. Should we be encouraging the use of OUD tapering strategies that have been proven to work?

Mr. Guth. Yes, and I think those goes back to the fact that you have very different presentations for folks. You have individuals with very different recovery capital themselves. So, not everybody needs to be on medication-assisted therapy for the duration. I think this gets back to one size doesn't fit

all.

Mr. Carter. Right, right.

Mr. Guth. So, the short answer to your question is, yes, we ought to be including in the continuum of care tapering strategies.

Mr. Carter. Okay. I want to talk real quickly about one of the bills that is under consideration. That is the Partnership Act, and that is the use of the PDMPs, and specifically as it relates to pharmacists. And full disclosure is, I suspect you know, currently, I am the only pharmacist serving in Congress. I have over 30 years of experience in a retail setting. And I acknowledge the responsibility of pharmacists. We have an important responsibility, a very important responsibility, as possibly the last line of defense in the opioid crisis.

But, having said that, I will tell you we are not policemen. And to require pharmacists to be the only ones to be looking at a PDMP, and to be policing physicians who are writing the prescriptions, I think is somewhat unfair. I have often said the only thing worse for me, as a practicing pharmacist, to fill a prescription for someone who is going to be abusing it, would be to not fill a prescription for someone who truly needs it. It is unfair to expect a pharmacist to profile a patient and say, no, that patient doesn't need that medication. That is unfair.

Now I get it. I understand a PDMP is different. I have sponsored the legislation creating the PDMP in the State of Georgia back in 2009. But, at the same time, I just want to get your thoughts on this. Without having the prescriber have to look at the PDMP, why are we having the pharmacist to look at it? To police the doctors? Anyone want to jump on that?

Yes, sir, Mr. Kravitz?

Mr. Kravitz. I think it is imperative that the provider be held accountable, prior to providing the prescription, that they must check the PDMP. And they are the source of this process. I think the pharmacist, which I have a daughter who is a pharmacist as well, and I think they are a checkpoint in the process. They should not be held accountable as the policing act.

Mr. Carter. Thank you.

Any other comments? Okay, and let me go back to you, Mr. Guth, because I thought it was interesting. In your opening statement, you said that the number of programs that are out there -- and this is something that I have been very concerned about, the fact that I look at the opioid crisis and I look at two different components of it.

First of all, there is that tangible part, if you will, that I feel like we can get our arms around. How do we control the number of prescriptions, the pills that are going out? And what

are those things that we do to limit the access to them?

But, then, there is the second component that is more challenging in my mind, and that is, how do we treat those people who are already addicted? You said that, quite often, it depends on what program you enter into.

Mr. Guth. Yes. And let me give you an example close to home of how we have addressed this. So, Centerstone has a five-state primary footprint for our services, and we are the result of an affiliation of nonprofit providers who are all mission-driven organizations. As we brought these organizations together, we realized that the systems of care in each of these states vary dramatically, not only in the area of substance use treatment --

Mr. Carter. Right.

Mr. Guth. -- but across the board, not based on the science of care, but based on how services evolved in those areas, access to human capital, state regulations, and, more often than not, funding, access to funding.

And so, what happens today is, let's take this shortage of services for the 30 million people in rural communities. We can quickly go to a solution that says let's give them access to medication-assisted therapy, light on the therapy, without all the continuum-of-care services. And we can turn around and say, hey, 30 million people now have access to substance abuse care.

But that is not a single solution that addresses all the people that present.

Think about the fact that, if you or I present with an opioid disorder, we have got a lot of human capital support around us in our family, in our friends, or networks. We have got jobs. We have got a safe place to live. But, if that is not our situation, which is the case for many people that are battling this disorder, we need to make sure they have got access to --

Mr. Carter. Right, right.

Mr. Guth. -- a sober living community, that they have got access to peer support.

Mr. Carter. Well, and it is one concern that I have because a lot of my colleagues -- and I am not being critical; I just don't think they understand -- think all we have got to do is throw money at it, and if we can get to a certain point, then that is where we need to be. But my point is that not all programs are going to work for all people.

Mr. Guth. That is right.

Mr. Carter. That is difficult for us in Congress to disseminate. How do we know which programs work and which ones don't?

Mr. Guth. I think you start by looking at whether the provider has access to, either directly or through strong referral relationships, a continuum of care.

Mr. Carter. A continuum of care is extremely important.

Mr. Guth. If anybody comes to you today and says, look, we have got the one solution, we have got the one program, the one protocol that is going to work for everybody, I think you ought to be looking very closely at that.

Mr. Carter. Right.

Let me ask one more thing. Mr. Douglas, or any of you, did I hear you say that only one out of five people in treatment are getting medication-assisted treatment? Are most of the patients who are under treatment for opioid addiction, are they getting medication-assisted treatment or are they just getting therapy? Almost all of them getting medication-assisted therapy?

Yes, I'm sorry?

Mr. Botticelli. So, despite the fact that I think all the data support that people on medication, as long as they are getting all the other behavioral and recovery supports, do far better on a medication versus treatment without the medications. But only a very small percentage of people are getting on it. And we still have a small percentage of our treatment programs who are even offering it.

But, while I agree with you that there are multiple pathways to treatment, I do think that every licensed substance use treatment provider who is getting a federal dollar should be offering access to medication-assisted treatment. And I think

it is really important because the data are pretty clear that people get into long-term recovery when they are on a medication versus when they are not.

And again, this is not saying "either/or". People need all the other recovery supports.

Mr. Carter. Right, right.

Mr. Botticelli. They need behavioral therapy. They need peer support services. But it is very clear, and again, I go back to Secretary Azar who said treating substance use disorders and treating opioid addiction without a medication is like treating an infection without an antibiotic.

Mr. Carter. Right.

Mr. Guth. And for the record, I absolutely agree with that. So, it is a point about having the other constellation services available.

Mr. Carter. Right. But you see what a difficult situation it puts us in. I mean, all of you know that this is a lifelong challenge. I mean, and you have to continue it, and it is expensive and everything else.

But I want to thank all of you for being here. This is extremely important. This is part of what, as I said earlier, the second component that I consider to be so very challenging for us, but so very necessary for those who need help. And we need them. We need them back to being productive members of our

society.

So, I will yield back the remainder of my time.

Seeing there are no further members wishing to ask questions, I would like to thank all of our witnesses again for being here today.

I would like to submit statements from the following for the record: the American Association of Oral and Maxillofacial Surgeons, the Association for Behavioral Health and Wellness, AdvaMed, the American Hospital Association, the American Psychological Association, the American Society of Health System Pharmacists, the Association for Community Affiliated Plans, the College of Healthcare Information Management Executives, ePrescribing Coalition, the National Association for Behavioral Healthcare, the National Association of Chain Drug Stores, the National Association of Medical Directors, the National Indian Health Board, the Oregon Community Health Information Network, the Partnership to Amend Part 2, the Pharmaceutical Care Management Association, Property Casualty Insurance Association of America, Shatterproof, Imprivata, the Pharmacy Coalition, Express Scripts, the National Association of Counties, and Trinity Health.

[The information follows:]

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

Mr. Carter. I would also like to submit a joint statement from the Infectious Disease Society of America, the HIV Medicine Association, and the Pediatric Infectious Disease Society; a study entitled, "States With Prescription Drug Monitoring Mandates Saw a Reduction in Opioids Prescribed to Medicaid Enrollees," published in Health Affairs, and the Center for Medicare and Medicaid Services 2016 Medicaid Drug Utilization Review Annual Report.

[The information follows:]

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

Mr. Carter. Pursuant to committee rules, I remind members that they have 10 business days to submit additional questions for the record, and I ask that witnesses submit their responses within 10 business days upon receipt of the questions.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:37 p.m., the subcommittee was adjourned.]