Written Statement of

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Before the

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"Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients"

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One-page Summary of Written Statement

- Addressing our nation's opioid crisis requires a multifaceted approach—from disrupting traditional healthcare models to new public policy, which will encourage more cross-system integration and help ensure access to comprehensive healthcare services. Magellan Health, Inc. (Magellan) believes turning the tide on the opioid crisis begins with each of us: individual healthcare stakeholders doing our part to help respond.

- This Subcommittee has provided an important, continual spotlight through multiple hearings and discussions with those involved on the front lines of this epidemic. Magellan commends the Subcommittee for its efforts to develop bipartisan legislation that addresses the multiple challenges to reduce and prevent opioid misuse and to provide treatment and recovery for those living with opioid use disorder (OUD).

- In support of the Subcommittee's work, we welcome the opportunity to share Magellan's thoughts about legislative ideas to improve the Medicare and Medicaid programs' abilities to ensure effective and efficient OUD treatment and services for enrollees.

- Magellan has been a strong advocate for policy solutions that promote clinically appropriate opioid prescribing, in addition to policies that support opioid misuse prevention and access to evidence-based, comprehensive OUD treatment and recovery services. These legislative ideas and policy solutions for the Subcommittee to consider include:
    - Addressing barriers to the capacity for, and access to, evidence-based, comprehensive substance use disorder treatment and recovery services, including:
        - Allowing other types of practitioners to be eligible to prescribe medication-assisted treatment (MAT);
        - Increasing Medicaid reimbursement for MAT when combined with psychosocial interventions to promote capacity and access; and,
        - Promoting the continuum of behavioral health services within the Medicare program, including all forms of MAT, psychosocial interventions and recovery supports (such as peer recovery support services), among others;
    - Facilitating care coordination and continuity by modernizing 42 C.F.R. Part 2 to allow the confidential sharing of information on substance use diagnosis and treatment between healthcare providers and with health plans and pharmacy benefit managers (PBMs) for the purposes of care coordination;
    - Optimizing the completeness and interoperability of state prescription drug monitoring programs, and extending access to health plans and PBMs; and,
    - Incentivizing other targeted and systemic solutions, including the appropriate prescribing of opioids through clinical and pharmacy management techniques and tools; requiring electronic prescribing of controlled substances; the expansion of accessible drug take-back programs and drug-disposal options; and, the extension of flexibility to health plans and PBMs to exclude and/or remove pharmacies engaging in fraudulent practices from their networks.

Written Statement of Sam K. Srivastava

Good morning Mr. Chairman, Ranking Member, and members of the Health Subcommittee. Thank you for the opportunity to be here today for this important conversation on the opportunities and challenges of addressing the opioid crisis within the Medicare and Medicaid programs. Addressing our nation's opioid crisis requires a multifaceted approach—from disrupting traditional healthcare models to new public policy, which will encourage more cross-system integration and help ensure access to comprehensive healthcare services. We also believe turning the tide on the opioid crisis begins with each of us: individual healthcare stakeholders doing our part to help mitigate and respond to this crisis.

As the Subcommittee knows well, opioid misuse and diversion have evolved into a health crisis affecting communities across the country. Only last week the Centers for Disease Control and Prevention (CDC) released an analysis concluding 63,632 individual lives were lost to drug overdoses in 2016, approximately two-thirds (or 42,000 individuals) of which involved a prescription or illicit opioid.[1] These stark figures reflect a 28 percent increase over 2015, suggesting – as the CDC states – "[t]he opioid overdose epidemic in the United States continues to worsen." While the scale and deepening of this crisis may seem self-evident, its broad scope and reach may not. These latest figures further suggest drug-overdose deaths from opioids increased in every demographic group; across rural, urban, and suburban communities; and, in each state and Washington, D.C. Unlike previous drug-related public health crises, this epidemic affects everyone—without regard for age, gender, race, or socioeconomic status.

1. Puja Seth, PhD; Lawrence Scholl, PhD; Rose A. Rudd, MSPH; and Sarah Bacon, PhD, "Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants – United States, 2015-2016," Centers for Disease Control and Prevention (CDC), *Morbidity and Mortality Weekly Report (MMWR)* 67, no. 12 (March 30, 2018): 349-358, https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6712a1-H.pdf. See also CDC, "Press Release: U.S. drug overdose deaths continue to rise; increase fueled by synthetic opioids" (March 29, 2018), https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html.

This Subcommittee – as well as the full House Energy and Commerce Committee, the House Ways and Means Committee, and the corresponding committees in the United States Senate – has provided an important, continual spotlight through multiple hearings and discussions with those involved on the front lines of this epidemic. We commend the Subcommittee for its work and its efforts to develop bipartisan legislation that deals with the multiple challenges to reduce and prevent addiction and to provide treatment and recovery for those who face this debilitating, chronic condition.

In support of the Subcommittee's work, we welcome the opportunity to share Magellan's own efforts to preempt and respond to the opioid crisis, and our thoughts about legislative ideas – specific to the prevention of, treatment for, and recovery from opioid use disorder (OUD) – to improve the Medicare and Medicaid programs' abilities to ensure effective and efficient healthcare, for enrollees, especially substance use disorder (SUD) treatment and services. We hope these experiential, practical, and policy contributions further support the Subcommittee's important work to address the crisis. Specifically, we believe investment in mental health and SUD treatment and services ("behavioral health services") is the most effective way to prevention addiction and mitigate ongoing effects of opioid misuse and diversion.

Magellan Health, Inc. (Magellan) started as a behavioral health company more than 40 years ago and has been an early pioneer in innovative, comprehensive models to promote, educate, and guide effective, evidence-based SUD prevention, treatment, and recovery services. Our experience supporting individuals living with mental health and substance use disorders (MH/SUDs) – including OUD – through complete-person care has demonstrated the importance of leaning into the complexity and interplay between an individual's behavioral, medical, and pharmaceutical

needs to positively impact overall health and wellness. This focus on complex population health, we believe, is essential for helping individuals living with SUDs, including OUD, and healthcare providers make the most informed decisions about the actions they can take to lead, or help their patients to lead, healthy, vibrant lives.

Today, Magellan provides behavioral health services to more than 25 million Americans through state Medicaid programs and Medicare; employer- and union-sponsored health plans, including approximately 100 health plans across the country; and, the U.S. Department of Defense, for which we provide family supports and behavioral health services to service members and their families. Within the Medicare program, we are a Part D Plan in 20 of the Centers for Medicare & Medicaid Services' (CMS's) 34 regions, and a Dual-Eligible Special Needs Plan and Medicare-Medicaid Plan in the northeast, covering both Medicare and Medicaid in Massachusetts and New York. We also serve more than 1.5 million Medicaid and Children's Health Insurance Program enrollees through a range of innovative state programs in four states (Florida, Massachusetts, New York, and Virginia), including:

- In the state of Florida, a pioneering approach to supporting people living with serious mental illness that is the first of its kind in the nation. Magellan Complete Care of Florida is a unique Medicaid specialty plan that connects behavioral, physical, pharmacy, and social needs—including supportive housing—into a plan of care that is individualized, coordinated, and cost effective.

- In the commonwealth of Pennsylvania, comprehensive county-based behavioral health services through the HealthChoices program in Bucks, Cambria, Delaware, Lehigh,

Montgomery, and Northampton counties. To help respond to the opioid crisis facing Pennsylvania's communities and townships, Magellan Behavioral Health of Pennsylvania helped increase access to SUD treatment and services, and utilization of medication assisted treatment (MAT), including new detox (40) and rehabilitation (100) beds, as well as increased methadone-maintenance capacity (245).[2]

- To help the commonwealth of Virginia respond to communities impacted by the opioid crisis, Magellan promotes capacity and access through the Governor's Access Plan (GAP), a new SUD benefit and delivery system, and the Addiction and Recovery Treatment Services (ARTS) demonstration program, a new comprehensive Medicaid SUD treatment benefit, which includes expanded as well as new SUD benefits and increased reimbursement rates for some services: expanded inpatient and community-based residential detoxification benefit, new peer recovery support services benefit, and expanded short-term SUD residential treatment benefit.

I. How Magellan Health is Helping to Address the Opioid Crisis

Magellan contracts with approximately 80,000 specialized and credentialed behavioral health providers nationwide. Given our focus on complete-person care, we also have built a full-service pharmacy benefit management (PBM) division, which today provides Medicaid pharmacy services to 26 states and the District of Columbia. These assets, plus our tools as a health plan, allow Magellan to take a uniquely comprehensive approach to the opioid crisis.

2. Figures are for 2015-16. See Magellan Health, "Magellan in Pennsylvania: A profile in collaboration," B-128rev5 (March 2017).

Magellan continues to work to facilitate consistency of, and appropriate practices for, prescribing opioids ("opioid stewardship"). In November 2017, Magellan Rx Management, Magellan's PBM division, announced the implementation of a standard formulary and utilization management approach consistent with the CDC's 2016 *Guideline for Prescribing Opioids for Chronic Pain*.[3]

Currently, under our standard formulary and utilization management approach, we limit the daily dosage of opioids dispensed based on the strength of the opioid. Under the same standard approach, we currently require the use of immediate-release formulations before extended-release opioid formulations are dispensed. In addition, starting in the first quarter of 2018, Magellan's standard formulary and utilization management approach began limiting the supply of opioid analgesics dispensed for certain acute prescriptions for individuals new to therapy to seven days.[4] We will enroll all of our clients utilizing our standard approach in all of these measures unless the client directs us to implement an alternative approach. However, even for those clients (whether it be state Medicaid programs, commercial health plans, or employers) choosing to develop an alternative, our practice is to consult with and recommend best practices – such as the CDC's 2016 *Guideline* – so our clients can make fully-informed decisions.

Our commitment to appropriate prescribing practices does not stop here. Magellan is taking a consistent leadership role in promoting screening, assessment, and evidence-based treatment for individuals with OUD and other SUDs, and is continuing to work with our public and private

3. CDC, "CDC Guideline for Prescribing Opioids for Chronic Pain," Recommendations and Reports, *MMWR* 65, no. 1 (March 18, 2016): 1-49, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.
4. Under our program (as with most utilization management rules), the patient is eligible for an exception only if the patient's physician provides information that satisfies the applicable clinical criteria for such an exception.

sector customers to implement and innovate opioids-related initiatives reflecting clinical, evidence-based guidelines, including:

A. Before opioids are prescribed, including by (1) *promoting evidence-based, including non-narcotic and non-pharmacological, pain management therapies*; (2) *piloting reSET®,* a U.S. Food and Drug Administration- (FDA-) approved digital alternative for pain management therapy[5]; and, (3) *expanding access to comprehensive, evidence-based behavioral health programs,* which identify and address MH/SUDs and other physical health conditions that may lead to misuse.[6]

B. When opioids are prescribed, including by (1) *applying clinical edits and dosing limits that reinforce CMS and CDC best practices*, including the CDC's 2016 *Guideline*, to require review and authorization of opioid prescriptions[7]; (2) *comprehensive drug utilization review and prior authorization criteria* for immediate- and extended-release formulations of opioids; (3) *claims surveillance, advanced analytics, and pharmacist-led academic detailing* using clinical algorithms to proactively identify potentially at-risk individuals and prescribers with increased risk factors; (4) *case management to proactively engage patients early in pain management treatment* using opioids to

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5. reSET® provides healthcare providers and patients with an evidence-based, non-pharmacological treatment option. The pilot is designed to improve education, treatment, and outcomes for individuals living with SUD. The pilot leverages advanced analytics to identify both physician and patient opportunities, including clinical outreach to provide detailed information on how to access reSET® once prescribed. Industry partnerships like this allow Magellan to rethink the way treatment is delivered and offer practical solutions to meet the complex needs we face because of this crisis.

6. Examples of these initiatives include: care coordination, which helps individuals access the MH/SUD treatment and services appropriate to them at the right time and from the right source, tapping into community resources, self-help tools, office-based and virtual providers, and treatment facilities; screen and engage, which helps providers in care settings quickly identify potential SUDs and refer individuals to treatment and services; Virtual Care Solutions, which bring the latest screenings, information and evidence-based treatments to a computer, tablet or smartphone, enabling individuals to actively participate in their treatment on their own terms and in their own time; and, digital cognitive behavioral therapy (CBT), which offers CBT modules for a number of MH/SUDs, providing access to care for individuals residing in rural and underserved communities and/or those who may otherwise not seek help.

7. Criteria includes number of claims, morphine milligram equivalent (MME) dose (to limit the daily dosage of opioids dispensed based on the strength of the opioid), and quantity and duration of treatment (to limit to a seven-day supply of opioids dispensed for acute prescriptions for individuals new to this form of pain management therapy).

reduce the likelihood of long-term therapy and prevent misuse; (5) *Opioid New Start*, which educates members who have been prescribed opioids for the first time; (6) *drug disposal assistance* to direct individuals to safe disposal facilities in their communities; and (7) *a toll-free hotline*, staffed by behavioral health experts and available 24/7 for individuals who need help understanding their opioid prescription or feel like they are (or are at risk of) misusing.

C. <u>If opioids are misused</u>, (1) *case management programs* employing specialized opioid addiction pathways to ensure members receive individualized treatment plans; (2) *office-based opioid treatment and MAT*, which increase access to SUD treatment and enable individuals with OUD to begin the journey to recovery in a comfortable and safe, community-based outpatient environment, avoiding hospitalization or institutionalization; (3) *peer recovery support programs*, including Certified Peer Support Specialists, or individuals in recovery from a SUD whom use their own lived experience with a SUD, including OUD, to help others on their road to recovery; and, (4) *MYLIFE, offered through our public-sector programs, including Medicaid,* a safe place for children, youth and young adults to discuss ways they or a loved one are impacted by mental health conditions and/or SUDs, including OUD, and providing support through a network of friends experiencing the same or similar circumstances.

II. <u>How Magellan Health is Partnering in Support of a Concerted Response to the Crisis</u>

We also are committed to a coordinated, multi-pronged, and collaborative, cross-stakeholder approach to addressing the opioid crisis. As a reflection of this, Magellan joined 15 other

healthcare payers to announce our joint endorsement of eight National Principles of Care for the identification, promotion, and reward of quality SUD treatment. (The principles were derived from the U.S. Surgeon General's 2016 report, *Facing Addiction in America*.) The initiative is part of the Substance Use Disorder Treatment Task Force, launched in April 2017 by Shatterproof. (Shatterproof is a national nonprofit organization, founded by a parent who lost a child to a substance use disorder, dedicated to ending the devastation SUDs cause families.)

In addition, Magellan is participating in America's Health Insurance Plans' Safe, Transparent Opioid Prescribing (STOP) initiative. The initiative – the product of collaboration between clinical experts and the health insurance industry – supports widespread adoption of the CDC's 2016 *Guideline* and other clinical guidance for pain care and appropriate opioid prescribing. We are using the initiative's STOP Measure – a robust, evidence-based methodology – to assess how participating providers' practices within our healthcare division, Magellan Healthcare, compare to the CDC's *Guideline*.

We also are working collaboratively to identify strategies to help physicians, clinicians, and other prescribers to manage better their patients' pain while reducing the risk of opioid misuse and diversion. Dr. Caroline Carney, chief medical officer for Behavioral and Specialty Healthcare, of Magellan Healthcare was named to the National Quality Forum National Quality Partners™ (NQP) Opioid Stewardship Action Team. The action team developed and published the *NQP Playbook™: Opioid Stewardship* (March 2018), which provides concrete strategies and implementation examples for clinicians committed to effective pain management, improving prescribing practices, and identifying strategies and tactics for managing care of individuals at high risk of misusing opioids, while building on current public- and private-sector efforts to address the

crisis. Magellan also has joined a private-sector coalition to form the Facing Addiction Gold Standard Alliance for the purposes of developing a gold-standard system of care for SUD screening, treatment and recovery, initially focused on alcohol use disorder and OUD.

Our commitment to a concerted, multi-stakeholder effort also includes the pharmacy industry, where Magellan joined eight other pharmacy care providers and PBMs in a joint letter to President Donald Trump highlighting steps we have taken to address the opioid crisis. Our letter highlights our joint pharmacy industry pledge to "manage opioid utilization consistent with the CDC's 2016 *Guideline* for opioid prescribing."

III. Legislative Ideas and Policy Solutions for the Subcommittee to Consider

In addition to the steps Magellan has taken as a company, we have been strong advocates for policy solutions that promote clinically appropriate opioid prescribing, in addition to policies that support opioid misuse prevention and access to evidence-based, comprehensive SUD treatment and recovery services. Our experience informs three areas (A.-C., below) where we believe changes could improve the Medicare and Medicaid programs' abilities to respond to and help address the opioid crisis. In addition, we have outlined a fourth, broader area (D., below) inclusive of several specific policy opportunities to help incentivize other targeted, and often systemic, policy solutions.

While we have not thoroughly reviewed each of the bills being discussed by the Subcommittee today, our initial analysis is the passage of this package of legislation would be a major step in the right direction. We agree with the Subcommittee: we must expand capacity for treatment and

recovery services. We must develop specific programs for at-risk populations. We must develop thoughtful, evidence-based mechanisms to limit access to these highly addictive pharmacological pain management therapies to only those where it is clinically appropriate. We must put in place faster, accessible, and more comprehensive information-sharing systems to help healthcare providers and care coordinators understand and clinically respond to an individual's controlled substance history, identify misuse, and mitigate unforeseen co-prescribing risks. We improve our ability to identify potentially inappropriate prescribing or dispensing practices, such as the co-prescribing of opioids and benzodiazepines or psychostimulants, and do so preemptively. We must modernize outdated privacy laws that limit a provider's ability to share information on substance use, which may hinder a provider from being able to make informed healthcare recommendations to patients. Each of these critical, individual policy components form an overall legislative framework to help address the opioid crisis in the Medicare and Medicaid programs.

A. Addressing barriers to capacity for, and access to, evidence-based, comprehensive SUD treatment and recovery services

In 2015, the U.S. Department of Health and Human Services (HHS) targeted three priority areas to address the opioid crisis: opioid prescribing practices to reduce OUD and overdose; expanded use and distribution of naloxone; and expansion of MAT to reduce OUD and overdose.[8] Research shows MAT when combined with psychosocial interventions, such as psychotherapy and peer recovery support services, is superior to MAT or psychosocial intervention on its own and significantly increases treatment adherence and reduces opioid misuse when compared with non-

8. U.S. Department of Health and Human Services (HHS), "Opioid abuse in the U.S. and HHS actions to address opioid-drug related overdoses and deaths" (2015), https://aspe.hhs.gov/basicreport/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths.

pharmacological (i.e., non-MAT) approaches.[9] Further, retention in MAT has been further associated with other beneficial outcomes, including decreased drug use, improved social functioning, and reduced mortality.[10]

The Substance Abuse and Mental Health Services Administration (SAMHSA), American Society of Addiction Medicine, and the National Council for Behavioral Health, among others, also have supported MAT when combined with psychosocial interventions for OUD treatment.[11] Specifically, SAMHSA has noted that the combination of MAT with psychosocial interventions "can have a synergistic or additive effect and improve outcomes" and that use of MAT is "reasonable, practical and a desirable trend that should be greatly expanded."[12] The President's Commission on Combating Drug Addiction and the Opioid Crisis also recommended MAT as a means for expanding access to effective OUD treatment.[13] Despite this extensive evidence and broad-based support, the use of MAT when combined with psychosocial interventions continues to be underutilized, representing a small percentage of individuals with OUD and other SUDs whom seek and are in need of treatment.[14]

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9. American Society of Addiction Medicine (ASAM), *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (2015), http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24; R.P. Mattick et al., "Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence," *Cochrane Database of Systematic Reviews* 3 (2009): CD002209; S.D. Comer et al., "Injectable, Sustained-Release Naltrexone for the Treatment of Opioid Dependence: A Randomized, Placebo-Controlled Trial," *Archives of General Psychiatry* 63, no. 2 (2006): 210-8; and P.J. Fudala et al., "Office-Based Treatment of Opiate Addiction With a Sublingual-Tablet Formulation of Buprenorphine and Naloxone," *New England Journal of Medicine* 349, no. 10 (2003): 949-58.
10. Christine Timko, Nicole R. Schultz, Michael A. Cucciare, Lisa Vittorio, and Christina Garrison-Diehn, "Retention in Medication-Assisted Treatment for Opiate Dependence: A Systematic Review," *Journal of Addictive Diseases* 35, no. 1 (2016): 22-35, https://doi.org/10.1080/10550887.2016.1100960.
11. The Pew Charitable Trusts, "Fact Sheet: MAT Improves Outcomes for Patients with OUD" (Nov. 22, 2016).
12. Substance Abuse and Mental Health Services Administration (SAMHSA), "Incorporating Alcohol Pharmacotherapies into Medical Practice: A Review of the Literature – Updates," Treatment Improvement Protocol (TIP) no. 49 (2012), https://store.samhsa.gov/shin/content/SMA12-4380/TIP49_Lit_Review_Updates.pdf.
13. The President's Commission on Combating Drug Addiction and the Opioid Crisis, *Final Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis* (Nov. 1, 2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.
14. Magellan Health (2016).

The numerous barriers to utilization of this evidence-based, comprehensive SUD treatment and recovery model reflect several larger factors. Firstly, each of the three FDA-approved forms of MAT play a different role in SUD treatment and may be clinically appropriate for some individuals with OUD but not others. Secondly, utilization of MAT is affected negatively by the limited number of professionals and paraprofessionals available with such training and experience.[15,16] According to SAMHSA, 48,626 providers currently are certified to prescribe MAT (i.e., hold a buprenorphine waiver under the Drug Addiction Treatment Act of 2000, or "DATA waiver"); of that current figure, approximately 72 percent are certified to prescribe MAT for 30 patients, with less than 20 percent (or 9,413) certified for 100 patients and 8 percent (or 4,100) for 275 patients.[17] When compared to the 900,000 providers able to prescribe oxycodone, these figures alone demonstrate the significant gap in MAT capacity.[18] As others have noted, "enlargement of the network of professionals authorized to deliver treatment and broadened access to MAT through such avenues as specialized community pharmacies, telemedicine and hub-and-spoke systems of care," including through behavioral health value-based payment models, continues to be an area of opportunity.[19]

Thirdly, as an extension of this secondary barrier (or a cause of it), many healthcare providers remain hesitant regarding the effectiveness of MAT, leading to a gap between the number of high-quality providers with training and experience to prescribe MAT and the individuals affected by

15. J. Albright et al., "Psychiatrist characteristics that influence use of buprenorphine medication-assisted treatment," *Journal of Addiction Medicine* 4, no. 4 (2010): 197-203.
16. A.H.S. Harris et al., "Pharmacotherapy of Alcohol Use Disorders in the Veterans Health Administration," *Psychiatric Services* 61, no. 4 (April 2010): 392-98.
17. SAMHSA, "Number of DATA-Certified Physicians," Updated Daily (accessed April 6, 2018), https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/physician-program-data.
18. Christine Vestal, "Few Doctors Are Willing, Able to Prescribe Powerful Anti-Addictions Drugs," *Stateline* (Jan. 15, 2016), the Pew Charitable Trusts, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/15/few-doctors-are-willing-able-to-prescribe-powerful-anti-addiction-drugs.
19. A.R. Williams and A. Bisaga, "From AIDS to opioids – how to combat an epidemic," *New England Journal of Medicine* 375, no. 9 (2016): 813-15.

OUD and other SUDs in need of treatment. Social stigma towards SUDs and MAT as a treatment modality is also a factor. (Indeed, despite the fact that approximately 75 percent of heroin users were introduced to opioids through prescription drugs, stigma continues to associate OUD and other SUDs with drug-seeking behavior and recreational use.[20,21]) In addition, educating the healthcare community on evidence-based MAT protocols is needed to address pre-conceived notions, cognitive bias, and the impact of both forms of stigma on treatment access, treatment and recovery outcomes, and reduction rates in patient motivation to maintain treatment regimens and counseling programs.[22] Professionals and paraprofessionals also need to find value in devoting more time to case management, which can promote the necessary complement of psychosocial interventions, while employing MAT protocols, which reduces the possibility of relapse and/or readmission to a SUD inpatient/residential rehabilitation program.

Fourth and finally, these logistical factors are compounded, at least in part, by variance and complexity in how MAT and the necessary psychosocial interventions are covered and paid for. While state Medicaid programs have implemented a range of policies to regulate and reduce prescription opioid use and misuse – including patient review and restriction in Medicaid fee-for-service or managed care, or both; preferred drug lists (PDLs); prescription drug monitoring programs (PDMPs); prior authorization requirements; and quantity limits on opioid dispensing – there remains opportunity for a similarly comprehensive effort to expand access to the full behavioral health continuum of care, specifically evidence-based, comprehensive SUD treatment

20. T.J. Cicero et al., "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years" *JAMA Psychiatry* 71, no. 7 (2014): 821-26.
21. B. Han et al., "Nonmedical Prescription Opioid Use and Use Disorders Among Adults Aged 19 Through 64 Years in the United States, 2003-13" *JAMA* 314, no. 14 (2015): 1468-78.
22. AMA Task Force to Reduce Opioid Abuse, "Patients with Addiction Need Treatment – Not Stigma," *ASAM Magazine* (Dec. 15, 2015), https://www.asam.org/magazine/read/article/2015/12/15/patients-with-a-substance-use-disorder-need-treatment---not-stigma.

and recovery services like MAT and psychosocial interventions.[23] (A 2014 survey found significant variance and complexity among state Medicaid programs' coverage and utilization review requirements for each FDA-approved form of MAT, including documentation and counseling requirements.[24] According to a 2013 survey, only 28 states at that time covered all three FDA-approved forms of MAT under Medicaid.[25]) Some of the FDA-approved forms of MAT (methadone, buprenorphine, naltrexone) may not be available on current formularies and PDLs, and other services used in SUD treatment may be at state Medicaid agency and Medicare Advantage plan discretion (e.g., counseling, licensed clinical social work services, targeted case management, medication therapy management, and peer recovery supports).[26,27]

For these reasons, Magellan is committed to taking steps to ensure MAT is more readily available and that it is paired closely with psychosocial interventions, such as psychotherapy, CBT, and peer recovery support services. Magellan works closely with healthcare providers, health plans, and the Medicare and Medicaid programs to increase comfort with, and knowledge of, the effectiveness of MAT and psychosocial interventions, to encourage prescription of MAT with psychosocial interventions, and to incorporate MAT into formularies. Magellan also collaborates with health plans and the Medicaid program to incorporate all forms of MAT into respective formularies to promote appropriate access. As an example, Magellan collaborated with Pennsylvania to facilitate SUD treatment services for Medicaid enrollees through the commonwealth's 20 Centers of

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23. A. Bernstein and N. Minor, "Medicaid Responds to the Opioid Epidemic: Regulating Prescribing and Finding Ways to Expand Treatment Access," *Health Affairs* Blog (April 11, 2017), http://healthaffairs.org/blog/2017/04/11/medicaid-responds-to-the-opioid-epidemic-regulating-prescribing-and-finding-ways-to-expand-treatment-access/.
24. ASAM, "Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment" (2014), https://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final.
25. Ibid.
26. Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC), "State Policies for Behavioral Health Services Covered under the State Plan" (June 2016), https://www.macpac.gov/publication/behavioral-health-state-plan-services/.
27. A. Bernstein, MACPAC, "Prescription Opioid Use in the Medicaid Population" (Oct. 27, 2016), https://www.macpac.gov/wp-content/uploads/2016/10/Prescription-Opiod-Use-in-the-Medicaid-Population.pdf.

Excellence (COEs). The COEs are a central, efficient hub around which individuals living with SUDs can receive both primary and behavioral healthcare services, including comprehensive MAT and psychosocial interventions, thereby improving access to evidence-based, SUD treatment and recovery services.

Magellan's Recommendations: **To improve further the adoption and availability of evidence-based MAT, we recommend the following:**

1. ***Allowing other types of practitioners to be eligible to prescribe MAT*, including nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.**

2. ***Prescribing MAT through the use of telehealth.* We recommend expanding the ability to prescribe MAT through use of telehealth so long as such services are preceded by an in-person evaluation and accompanied by periodic face-to-face evaluations to ensure appropriateness of care.**

3. ***Increasing Medicaid reimbursement for MAT and psychosocial interventions to promote capacity and access.* We encourage the Subcommittee to consider a temporary "pay bump," or other increased reimbursement incentive, to promote greater SUD workforce capacity for MAT and psychosocial interventions in the Medicaid program.**

4. ***Promoting increased capacity for, and access to, MAT within the Medicare program.*** **Within the Medicare program, we recommend coverage of all forms of MAT when dispensed through an OUD program (i.e., inclusive of psychosocial interventions and recovery supports). We further recommend allowing qualified providers, who are appropriately licensed to dispense MAT (and possess a DATA waiver), to enroll in Medicare Part B. We also encourage Medicare to provide access to evidence-based, non-pharmacological and non-addictive pharmacological therapies for pain management, as well as a continuum of behavioral health services in support of MAT, including psychosocial interventions and wrap-around recovery supports such as digital CBT and peer recovery support services.**

5. ***Promoting best practices across state Medicaid programs.*** **Magellan recommends CMS issue further guidance to state Medicaid programs detailing best practices for lessening disparities in Medicaid coverage and related requirements for coverage of SUD treatment and recovery services, such as the inclusion (1) of all FDA-approved forms of MAT on current formularies and placing naloxone on the PDL; and (2) as covered benefits, inpatient and outpatient detoxification, psychotherapy and counseling, peer recovery support services, and other community-based services and supports. We also recommend increasing the use of digital tools and technology used for SUD treatment and recovery, including digital CBT programs and web-based modules or apps. (These tools can strengthen peer recovery support services by improving access to evidence-based information and social supports.) We**

recommend expanding access to recovery services, including ongoing, evidence-based psychiatric treatment, wrap-around services, and peer recovery support services.[28]

6. ***Encouraging the development and adoption of comprehensive Medicaid programs for SUD treatment and recovery.*** **To best bring these elements (i.e., Item 5) together, Magellan recommends mechanisms – such as a time-limited federal medical assistance percentage (FMAP) increase – for encouraging the development and implementation by states of comprehensive Medicaid initiatives for SUD treatment. An example of such a comprehensive Medicaid initiative is the Virginia GAP and ARTS programs, which expanded the Medicaid SUD treatment benefit and further integrated inpatient and outpatient treatment with community-based recovery supports. We also recommend Congress encourage CMS to assess and share emerging models and promising practices within the Medicaid program to address the opioid crisis.**

7. ***Increasing provider awareness of MAT and other evidence-based SUD treatment and recovery modalities.*** **Magellan further recommends Congress encourage CMS to partner with the Health Resources and Services Administration (HRSA), SAMHSA, and medical and professional societies to increase provider:**

28. Research has also shown that peer support is beneficial and cost-effective; peer specialist support programs in Wisconsin, New York, and Washington State reduced inpatient days by up to 63 percent, and decreased overall MH/SUD costs by approximately 47 percent.

a. Comfort and knowledge of the proven effectiveness of MAT;

b. Familiarity with evidence-based protocols for treatment;

c. Training in the use of MAT and psychosocial interventions; and,

d. Education and training on pain treatment and management, including effective, alternative/non-opioid therapies for pain management, safe opioid prescribing, and preventing the consequences of opioid misuse and overuse through tapering and other opioid-management strategies.

We also believe CMS, HRSA, and SAMHSA should incorporate MAT competencies and accreditation standards into academic curricula across medical, social service and criminal justice disciplines.

8. *Supporting a high quality, effective SUD treatment and recovery continuum.* We also recommend Congress encourage CMS and national accrediting bodies to collaborate and advance a nationally recognized mechanism to ensure accreditation of SUD treatment and service providers, with the future potential to include COE designations and to limit federal Medicare and Medicaid reimbursement only to accredited providers.

9. *Promoting healthcare transitions for individuals living with OUD and/or other SUD(s) whom are formerly incarcerated.* We also strongly support additional resources for immediate "warm" handoffs (i.e., supported healthcare coverage and service transitions) to OUD and/or SUD treatment for Medicaid and

Medicare enrollees in emergency departments after overdose and connecting family caregivers to appropriate support groups.

B. Facilitating care coordination and continuity by modernizing 42 C.F.R. Part 2

The vast majority of today's integrated care models rely on Health Insurance Portability and Accountability Act- (HIPAA-) permissible disclosures and information sharing to support care coordination—that is, without the need for the individual's written consent to share relevant treatment details, provider by provider. The same is true for the modern electronic infrastructure for information exchange. In an era of electronic medical records (EMRs), having incomplete records available for providers—because substance use disorder information (the confidentiality of which is governed separately, by 42 C.F.R. Part) cannot be included without individual consent—disallows providers from supporting their patients holistically. In some case, providers may believe the EMR (to which they have access) reflects their patient's complete clinical history. In such situations, a provider may prescribe, for example, opiates for back pain for a member with prior history of opioid misuse, which could lead to relapse. Access to complete medical information is critical for providers to ensure individuals have access to the healthcare services, supports, and treatments appropriate to their needs. In order for Medicare and Medicaid enrollees to receive the full benefits of integrated care, particularly enrollees with OUD and other SUDs, the care coordination exception permitted under HIPAA is necessary for 42 C.F.R. Part 2-governed SUD information.

Furthermore, while having to obtain any written consent is a barrier to achieving care coordination, the ability to obtain a more broad consent would certainly permit member information to be shared

more easily for care coordination and treatment purposes. It would also make it easier to include information in EMR systems noting whether the consent was constrained to individual providers. Consents having to list individual providers often have to be obtained repeatedly as members move through the system of care, leading to delays or barriers in coordinating a member's care. These hurdles are extremely problematic for health plan entities who are responsible for coordinating the care received by their members to make certain it is optimally suited for each member; any change of provider by the member necessitates a new written consent. In the event a member changes their primary care provider, switches psychiatrists, or begins a new course of treatment with a cardiologist – all of whom need to know about the member's SUD treatment history to ensure patient safety and proper treatment approaches – a new written consent must be obtained. Doing so is not always easy, particularly if the Medicare or Medicaid enrollee is unable to effectively understand or communicate due to their condition; or has other co-occurring conditions (such as a serious mental illness), which stymie the consent-collection process.

It is our belief – rooted in extensive experience with the behavioral health continuum in the Medicare and Medicaid programs – that the national opioid crisis is not being addressed nearly as effectively as it could be given the limitations posed by Part 2 on effectively coordinating care. For example, when a health plan is coordinating a Medicaid enrollee's discharge from an inpatient detox facility and attempting to locate an appropriate outpatient therapist in the community, the Medicaid health plan is prohibited from informing the outpatient therapist that their new patient has a SUD diagnosis and was discharged from detox, and must hope that: the detox facility notifies the therapist of the treatment directly (although they – the therapist – too would first need to obtain written consent to do so as well); the therapist asks the member about any SUD history (and that the member responds truthfully); or, the member is forthcoming enough to inform the therapist

proactively. If none of these occurs, the therapist's treatment plan will not address the crux of the Medicaid enrollee's healthcare needs – their OUD or other substance use disorder – potentially leaving the individual at greater risk of relapse, re-admission, or worse.

Similarly, when a detox facility calls the enrollee's Medicaid health plan for pre-authorization, the health plan is prohibited from advising the facility that this member could have been in detox multiple times in the past year and – as a result – may need their treatment approach adjusted accordingly to improve the member's quality of care and overall outcome. An enrollee with a SUD may not provide the Medicaid health plan with written consent and may not share his or her treatment history with the facility, leaving the facility in the position of being unaware of this critical information and providing treatment or treatment recommendations in the dark. Other effects on care and health outcomes that Magellan has encountered in coordinating the primary and behavioral healthcare services of Medicare and Medicaid enrollees in compliance with Part 2 include:

- Due to the need to exclude SUD data from the information sharing necessary to successfully coordinate an enrollee's care, the regulations result in fragmentation in treatment, less than optimal patient assessments, and treatment plans often created in a vacuum because the complete clinical picture is not available to the current provider, which can lead to adverse drug reactions, accidental overdose, inappropriate diagnosis, and ineffective treatment which targets the incorrect condition;

- The need to single out specific patient written consent for each individual provider prior to any disclosure of SUD information slows the treatment process considerably, creates great

inefficiencies, and may actually result in reinforcement of stigma associated with SUD treatment and services instead of overcoming it; and,

- The inability to share substance use patient information between providers without the express, written consent of the patient has created perceived liability situations for many physicians and other clinicians to the point that they may opt to refuse to treat any patient with a suspected history of substance use, particularly in primary care, which is most unfortunate since primary care providers often are in the most advantageous position to screen for and treat substance use disorders.

In our experience, we have seen multiple individual situations and dynamics adversely affected by Part 2. For these reasons, Magellan believes it is critical for healthcare providers and health plans to be able to assist their patients and members in recovery and with relapse prevention by sharing valuable SUD information – particularly when arranging for pre-authorization, referrals, step-down services, residential treatment, and other care coordination activities –without the need to obtain written consent for each individual provider. Health plans have a critical role in supporting improved health outcomes, mitigating opioid misuse, supporting individuals in recovery, and preventing relapse. The ability to use and disclose Part 2 information for these express purposes remains an unintended barrier to advancing screening, assessment, and evidence-based treatment for individuals at-risk of opioid misuse and individuals living with OUD and other SUDs.

Magellan's Recommendations: **Magellan strongly recommends the statute be amended to permit the sharing of SUD information for the purposes of treatment and health care**

operations as defined by HIPAA. Also essential as part of this modernization of Part 2 is the express permissibility of SUD information's inclusion in EMRs.

C. Optimizing the completeness, workflow integration and interoperability of state PDMPs and extending access to such databases to health plans and PBMs

State PDMPs have been implemented in all but one state; despite this growth, only 31 states' Medicaid programs and Washington, D.C.'s program are authorized to access state PDMP database information.[29] In those states that do extend access, health plans, PBMs, behavioral health organizations, administrative services organizations, and/or other sub-contractors to state Medicaid programs and to the Medicare program – entities administering Medicare and Medicaid prescription drug benefits and SUD treatments and services – may not have access to PDMP data. These restrictions often extend across state lines, with wide variation with respect to whether or how database information is shared with other states. In addition, data collection intervals vary by state who oversee their own drug monitoring programs, with only a few states currently requiring real-time reporting on controlled substances to their PDMPs and some states excluding short-term prescriptions from database reporting requirements.

When and where PDMP data can be accessed by the Medicare and/or Medicaid program and the program's contractors, data have not been well integrated into health IT systems or into professionals' and paraprofessionals', including prescribers', routines and patient protocols.

29. Bernstein and Minor, *Health Affairs* (2017); Bernstein, MACPAC (2016).

Compounded by the fact that as many as one-third of primary care physicians may not be aware of these state databases, PDMPs often are underutilized by providers.[30]

Magellan's Recommendations: **Magellan recommends all Medicare and Medicaid providers check the prescription drug history of Medicare and Medicaid enrollees through the applicable state's PDMP prior to dispensing an opioid. We also recommend Congress consider legislative ideas (e.g., increased FMAP for expenditures related to improving the PDMP in line with such activities) for encouraging states to (1) allow public payers, including Medicaid and Medicare, and their subcontractors (i.e., Medicaid health plans and PBMs, Medicare Advantage plans, and Part D plan sponsors, and the contractor's "pharmacy director (or a designee)"), to access the PDMP; (2) make their PDMPs more easily accessible, including direct access or a daily data feed that can be synched with existing Medicare and Medicaid data systems; (3) ensure data accuracy and availability in as close to real time as is feasible; (4) better integrate across the country by ensuring state PDMP interoperability with other states; (5) improve completeness, workflow integration, and interoperability of PDMP reports into EMRs and HIEs to streamline provider and payer access and usability to allow these entities and supporting providers to have a comprehensive, real-time look at a patient's clinical history; (6) partner with medical and professional societies to enhance education and training on availability of state PDMP databases and incorporating provider check requirements into daily routines and patient protocols to encourage real-time reporting; and (7) make PDMPs easier to use and report into by allowing prescribers to establish delegate accounts.**

30. L. Rutkow et al., "Most Primary Care Physicians are Aware of PDMPs, But Many Find the Data Difficult to Access" *Health Affairs* 34 (2015): 484-92.

D. Incentivizing other targeted and systemic solutions

The scale and reach of the opioid crisis requires systemic solutions in addition to targeted approaches to mitigating barriers to information sharing and access to treatment and services, as we have suggested in our preceding recommendations. The following additional policy solutions—including those that have been tested by the experience of states embarking on state opioid crisis strategies and task-force activities—represent approaches to tackling some of the systemic roots of the opioid crisis:

1. ***Encourage the appropriate prescribing of opioids through clinical and pharmacy management techniques and tools***

Between 1999 and 2014, the prescribing and dispensing of opioids "nearly quadrupled," according to the CDC, "but there has not been an overall change in the amount of pain Americans report."[31] While the rate of opioid prescribing has decreased in the period since 2014 (from 72.4 opioid prescriptions per 100 persons in 2006, increasing 1.1 percent annually through 2012), the supply of prescription opioids remains high in the U.S.: approximately 66.5 opioid prescriptions per 100 person in 2016.[32] These figures are stark when put into context: in 2013, approximately 250 million opioid prescriptions were written by healthcare providers — or a prescription for every adult in our nation. Ensuring appropriate prescribing of opioids (or opioid stewardship) requires each of us to rethink the treatment and management of acute or episodic pain—particularly since prescription

31. CDC, "Vital Signs: Overdoses of Prescription Opioid Pain Relievers — United States, 1999-2008" *MMWR* 60, no. 43 (Nov. 4, 2011): 1487-1492, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w%20-%20fig2. See also CDC, "Prescribing Data" (Aug. 30, 2017), https://www.cdc.gov/drugoverdose/data/prescribing.html.
32. CDC, National Center for Injury Prevention and Control, "Annual Surveillance Report of Drug-related Risks and Outcomes, United States" (2017), https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf

opioid use has become deeply entrenched in our clinical treatment culture. This rethink, however, must balance carefully the reality that at least 116 million Americans live with common chronic pain conditions, whose pain may be well managed with a prescription opioid today.[33]

Striking this balance can prove challenging but is possible through the development of thoughtful, evidence-based protocols for physicians and pharmacists to prevent patients from being prescribed inappropriately addictive, pharmacological pain management therapies, such as opioids. These protocols may include reasonable medical management techniques, such as prior authorization and quantity limits, consistent with best practices. The CDC's 2016 *Guideline*, for example, includes recommendations such as: using non-opioid and non-pharmacological pain management therapies as a first line of therapy; prescribing the lowest dose and fewest opioids that would be effective when opioids are appropriate; regularly reviewing the risks associated with opioids with patients; and, closely monitoring patients to promote safer use and improved health and wellness outcomes. These medical management tools also can be used to support value-based approaches to ensure individuals served by the Medicare and Medicaid program have access to effective and efficient healthcare to meet their unique needs.

Another key part of this is data: analyzing pharmacy claims information to identify when Medicare and Medicaid enrollees may be at risk of being prescribed opioids inappropriately, or in inappropriate amounts, including from multiple clinicians or in spite of a clinical history of OUD and/or other SUD. PDMPs, accessible by health plan and PBM physicians and pharmacists, are another valuable tool to help identify Medicare and Medicaid enrollees who may be receiving

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33. Institute of Medicine, Committee on Advancing Pain Research, Care, and Education, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research,* Washington, D.C.: National Academies Press (2011), https://www.ncbi.nlm.nih.gov/pubmed/22553896 (accessed April 9, 2018).

opioids from multiple providers and pharmacies, or through cash payment. In some circumstances, this data can and should be used to designate a single physician and a single pharmacy (i.e., a provider- or pharmacy-assignment program, also known as "lock-in") for individuals who may benefit from closer clinical engagement to address potentially inappropriate prescribing or misuse, carefully review for potentially dangerous co-prescribing, mitigate the risk of unintentional overdose, reduce hospital and emergency department admissions, and increase appropriate access to SUD treatment and recovery services.

Magellan's Recommendations: **Magellan recommends Congress consider legislative ideas for incentivizing the broad adoption of provider- and pharmacy-assignment programs, or lock-in, by state Medicaid programs, with flexibility to allow states to align the definition of at-risk beneficiaries with the Medicare program's new lock-in authority and/or existing state criteria reflecting certain minimum standards the subcommittee believes are appropriate. We also recommend state Medicaid programs have in place comprehensive drug utilization review activities, including medical management techniques and tools aligning opioid stewardship with the CDC's 2016** ***Guideline.***

2. ***Require electronic prescribing of opioids***

Fraud and abuse associated with paper-based prescriptions have been identified as a contributing factor to doctor- and pharmacy-shopping for opioids. Electronic prescribing (e-prescribing) can be an effective solution where health IT infrastructure is supportive, including benefits for providers, patients, payers and programs: improved monitoring of opioid use, reduced fraud through secure transmittal between providers and pharmacies, and improved patient safety via clinical alerts that

prevent adverse drug events in part by combining medical history with automated clinical decisions support.

Magellan's Recommendation: **Magellan recommends Medicare and Medicaid providers be required – where local health IT infrastructure is supportive – or, at minimum, incentivized to e-prescribe opioids and other Schedule II controlled substances as a tool to mitigate opioid misuse.**

3. *Expand accessible, community-based drug take-back programs and/or safe, in-home drug disposal options*

States increasingly are collaborating with local coalitions, pharmacies, health professional boards, and the U.S. Drug Enforcement Administration (DEA) in drug take-back or drug disposal programs, which offer a safe and anonymous way to dispose leftover opioid and/or other prescription drugs, including other controlled substances, which can be diverted and misused. Greater expansion of these local initiatives, including by expanding permanent drop-off locations and investing in innovative approaches to in-home drug disposal, can promote proper disposal of prescription opiates.

Magellan's Recommendation: **Magellan recommends CMS and the DEA coordinate to ensure compliance and participation costs of hosting permanent drop-off locations do not create unintentional barriers to local law enforcement, pharmacies and other entities establishing and expanding the availability of drug take-back sites and programs.**

4. ***Extend flexibility to health plans and PBMs to exclude, remove pharmacies engaging in fraudulent practices***

"Any willing provider" and other pharmacy-network laws pose difficulties for Medicaid health plans, Medicaid PBMs, Medicare Advantage-Part D plans, and Part D plan sponsors to exclude and remove pharmacies from their plan- and provider-contracted networks that engage in fraudulent practices. Requiring health plans to allow any pharmacy willing to accept its terms and conditions to participate in its networks severely restricts a plan's ability to exclude these so-called rogue pharmacies and enhance the quality of its pharmacy services for patients.

Magellan's Recommendation: **Magellan recommends Congress permit health plans and PBMs supporting the pharmacy benefits under the Medicare and Medicaid programs the flexibility to exclude and remove pharmacies engaging in fraudulent practices from their networks. We also recommend Part D plan sponsors be allowed to stop payment of suspect claims where there is a credible allegation of fraud.**

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A multifaceted approach is needed to address the evolution of this epidemic in real-time and to respond to the real-life effects of misuse and overuse. Both practical and policy solutions are needed here in Washington, D.C. and in state capitols across the country. Practical solutions include naloxone availability, safe and fully informed prescribing practices, easy and accessible disposal mechanisms, harm-reduction services, linkage into SUD treatment and wrap-around services, and further integration of primary and behavioral healthcare. Policy solutions are needed

to address the unintended gaps and barriers that make it harder for the Medicare and Medicaid programs to provide the best healthcare for enrollees.

Opioid dependence and addiction can start with triggers like acute pain, chronic pain, or surgery. Lack of education and awareness, or inappropriate prescribing practices, also can lead to misuse and abuse. Magellan recognizes that its work to address the opioid crisis must begin on the front end. It must help educate on the potential risks of prescription opioids and provide chronic care pain management, supported by personal health coaches and clinical experts in pain and addiction management, to help our Medicare and Medicaid members manage their pain without turning to opioids. It must help screen and engage to quickly identify potential problems and direct our members to treatment, including digital CBT and the broader use of personalized health technology that supports individuals actively participating in their own treatment on their own terms. Moreover, it must work to provide the lowest level of intervention for a specific healthcare issue or procedure to minimize or postpone the need for surgery that could lead to an opioid prescription, as clinically appropriate.

We would like to, again, thank the Subcommittee for the opportunity to share our experience and recommendations on how to address this national crisis. Magellan has a long history of providing evidence-based, comprehensive, and effective services to those living with substance use disorders. We provide integrated and comprehensive opioid risk and substance use management programs by bringing together behavioral, medical, and pharmaceutical programs to make a difference in people’s lives. Magellan has seen first-hand the magnitude of the opioid crisis and its impact on communities and families. We look forward to working with the Subcommittee in partnership to address this crisis facing our nation.