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ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

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May 2, 2018

Ms. Kimberly Brandt
Principal Deputy Administrator for Operations
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brandt:

Thank you for appearing before the Subcommittee on Health on April 11, 2018, to testify at the hearing entitled "Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on May 15, 2018. Your responses should be mailed to Zack Dareshori, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to zack.dareshori@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record

The Honorable Michael C. Burgess, M.D.

1. Virtually every stakeholder group that I have met with agrees that the IMD exclusion should be repealed as part of Congress ensuring Medicaid patients have access to a conntiuum of care. Many things have changed since the 1960s when this payment rule was adopted and now it is widely recognized that residential treatment is appropriate for some beneficiaries with substance use disorder. A full repeal of the IMD exclusion is still cost-prohibitive, with the Congressional Budget Office pegging the price tag of that policy at about $60 billion. But before us we have 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. This allows for longer treatment periods for all beneficiaries, not just selected subpopulations. Do you agree that a partial repeal of IMD is a good first step to ensuring that Medicaid beneficiaries receive the care they need? If so, how quickly so you think states will be able to react to this change?

2. I was pleased to see you mentioned in your testimony CMS's efforts to keep moving forward on Transformed Medicaid Statistical Information System. I am glad to hear that 49 states, DC, and Puerto Rico are reporting data now through this system. More accurate and timely Medicaid data is important for helping us combat the opioid crisis and it's important for improving Medicaid's role as a payer overall. As you know, Ranking Member Pallone and I, along with our counterparts in the Senate, sent the Administrator a letter on March 16th asking about the agency's progress implementing Transformed Medicaid Statistical Information System. I look forward to a formal response to that letter in coming days, but I want to ask about a comment in your testimony. You noted T-MSIS includes data on prescription opioids, and CMS is thinking about how to work with states in innovative ways to use this data in a way that will augment efforts to combat opioid misuse. Certainly, there is bipartisan interest in understanding how CMS is overseeing drug spending in the Medicaid program – whether it's the Medicaid drug rebate program, or the role of opioids, or other issues. While I know the data is imperfect, could CMS start releasing some sample data so Congress and the public have better information?
3. To help move the ball forward on this Medicaid data initiative, what does it take to boost CMS plans to use for program oversight efforts – do you need more resources and staff to move faster on this?

4. MACPAC and CMS have highlighted research that shows that patients enrolled in Medicaid have a higher risk of opioid overdose than patients covered by other payers. As a physician, I understand many Medicaid patients may have chronic conditions and long-term pain that can skew what the data looks like. I believe CMS and states share my concern over the vulnerability of Medicaid patients emphasized in these reports. Can you explain what CMS is doing to conduct oversight of state Medicaid programs and partner with them to drill down on the areas of vulnerability and protect patients who may be at risk of opioid misuse or overdose?

5. The Medicaid PARTNERSHIP Act will allow state flexibility in how states design their PDMP programs. However, it also ensures that PDMPS are a part of Medicaid provider's clinical workflow, which is critically important, given that a 2014 national survey "found that 53 percent of primary care physicians used their state's program at least once, but that many did not use it routinely." If more physicians and pharmacists were checking the PDMP would you expect the number of unsafe prescriptions of opioids to decrease?

6. Representative Tonko's bill would allow states to use federal Medicaid dollars to pay for treatment of prisoners 30-days prior to release back into the community. So, for example an inmate with substance use disorder Medicaid would pay for the first Vivitrol shot and subsequent shots would be given after release. I understand that the incarcerated population needs to be part of our opioid discussion, but I am worried about states just shifting costs to CMS. It seems like we can do better coordination under current law, without spending billions of Medicaid dollars more on prisoners. For example, Pennsylvania has a program where the state Department of Corrections pays for the first shot of Vivitrol and then after release, if the inmate is eligible for Medicaid, Medicaid picks up the costs for subsequent shots. If Pennsylvania can figure out how to do this, why can't other states under current law?

7. There are currently non-incarcerated people who may be low-income and uninsured, and some may even be Medicaid eligible. For example, a study in San Diego concluded that nearly 80% of more than 13,000 uninsured patients in in hospital emergency departments over 11 months were eligible for some form of government insurance. Shouldn't we prioritize non-criminals first? Wouldn't it make sense to prioritize a low-income, but uninsured group and help facilitate their enrollment into Medicaid first?

8. Numerous studies have found that Medicaid enrollees have excessive burdens of chronic pain and are at a much higher risk of substance use disorders compared to populations with other types of insurance. Similar studies have found that Medicaid enrollees are thus at heightened risk for prescription opioid misuse and were five to six times as likely to die from opioid-related overdose compared to populations with other types of insurance. Because of this, according to the authors of one such study (which I would like to submit for the record), "reducing the number of unsafe prescriptions of opioids in the Medicaid population should be a priority for any drug control policies." I believe that we have several bills before us today that will help achieve that goal. Our Pharmacy Home Bill, our PDMP Bill, and our DUR bill for example. Does the Administration believe that these policies will help to advance the important goal of reducing the number of opioids in the Medicaid population?

9. Last fall, CMS released its 2016 Drug Utilization Review report. The report noted that 26 Medicaid agencies have access to PDMP data. States can use PDMP data 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 PDMP data. Given how some states have seen PDMPs help protect patients and reduce reliance on opioids, I think that this bill helps those states equip the Medicaid agency with an important tool that can be used to fight this epidemic. Can you describe how Medicaid agency officials would use PDMP data to combat opioids?

10. I have a question pertaining to the Medicaid Pharmacy Home Act, which requires states to have a provider/pharmacy assignment program for patients whom the state identifies as potentially misusing or abusing controlled drugs. In 2012, CMS highlighted the importance of these "lock-in" programs as an element of a robust state Medicaid controlled prescription drug program. This past October, CMS released its annual Drug Utilization Review report. The report notes that while 48 states are currently using lock-in programs, some states make lock-in programs optional for managed care organizations. Lock-in programs are effective in reducing overprescribing and in states like Pennsylvania and New York the program has resulted in reducing patient harm and saved money due to curbing unnecessary utilization. The Pharmacy Home Act codifies a requirement that requires Medicaid managed care plans have a similar program. Can you think of a reason why managed care organizations should not be asked to use this important tool?

11. I want to address a point that my colleague brought up about lock-in programs being used to theoretically deny Medicaid beneficiaries prescription drugs they need or restrict access. Not only do I see that the bill exempts populations for the program such as beneficiaries in hospice, but I am aware of a 2016 Pew Charitable Trust Report which showed that 38 of 41 states surveyed operate a similar program. If lock-in programs really are meant to restrict access and deny people drugs they medically need, why is it that both Republican and Democratic states are using them? I think such critiques are misleading smokescreens. We are here to adopt proven technological solutions that help protect patients and ensure they get the care they need. If members and stakeholders want to be thoughtful and have constructive improvements to the draft proposal, we certainly welcome them.

12. In your testimony, you discussed Medicare's Overutilization Monitoring Program which helps plans identify at-risk beneficiaries so plans can take appropriate clinical steps to prevent opioid misuse or overdoses. Does this program also share this data with state Medicaid programs so they can ensure the best care for beneficiaries who are dually enrolled in Medicare and Medicaid?

    a. If yes, can you explain how the process works to get this information to state programs and how quickly this process works?

    b. If no, can you please have your staff look into the feasibility of sharing this data with state programs and get back with the Committee?

13. In your testimony, you describe how Medicare Part D plans receive the quarterly pharmacy risk assessments which list pharmacies identified by CMS at high risk. Does CMS also share this data with state Medicaid programs to help ensure the best care for patients who are dually enrolled in Medicare and Medicaid?

    a. If not, would CMS be willing to look at how it might be possible to share this data with state programs and get back with the Committee?

14. The National Association of Boards of Pharmacy reports that 39 states already mandate use of PDMPs. What has your experience been in using PDMPs to combat the opioid crisis? What is your sense on how providers and dispensers view the usefulness of PDMPs?

15. Numerous studies have found that Medicaid enrollees have excessive burdens of chronic pain and are at a much higher risk of substance use disorders compared to populations with other types of insurance. Similar studies have found that Medicaid enrollees are thus at heightened risk for prescription opioid misuse and were five to six times as likely to die from opioid-related overdose compared to populations with other types of insurance. Because of this, according to the authors of one such study, which I quote: "reducing the number of unsafe prescriptions of opioids in the Medicaid population should be a priority for any drug control policies." I believe that we have several bills before us today that will help achieve that goal. Our Pharmacy Home Bill, our PDMP Bill, and our DUR bill for example. Do you believe that these policies will help to advance the important goal of reducing the number of opioids in the Medicaid population?

16. The Medicaid HUMAN CAPITAL Act would provide enhanced funding for states to recruit highly-experienced Medicaid directors, Chief Information Officers, and Chief Financial Officers. In Mr. Douglas's testimony, he discusses the importance of strengthening Medicaid's role as a payer in combatting opioid misuse. He notes "Congress should implement policies that support state recruitment and retention of strong Medicaid executive leadership," because as he explains, a stable and strong state leadership will be best equipped to respond to the opioid crisis and further public health crises." In your opinion, is it helpful to improving Medicaid's role in addressing the opioid epidemic and other public health challenges by helping states secure the most talented, innovative, and experienced leadership possible?

17. I am interested in the draft that proposes a demonstration project to increase provider capacity in Medicaid for treating substance use disorder. States could apply to use the funds to recruit or train current or new providers. However, I do have several concerns with the idea. Given all the funds that Congress has authorized to support provider capacity such as GME as well as grants from HRSA, SAMSHA, and CDC. Is this idea duplicative? I am also unclear why we would start a new program when those are well established and have staff that understand workforce capacity. Can you comment on that?

The Honorable Leonard Lance

The 2019 Call Letter states that Part D beneficiaries with cancer-related pain are excluded from the 'Overutilization Monitoring System.' Can you please clarify how CMS intends to also exclude patients diagnosed with conditions beyond cancer but that are cancer-like in their association with extreme pain?