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ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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May 2, 2018

Mr. Sam Srivastava
CEO
Magellan Health
55 Nod Road
Avon, CT 06001

Dear Mr. Srivastava:

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. The Centers for Medicare and Medicaid Services recently released its annual Drug Utilization Review report. (submit for the record) I was surprised to learn 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 significant savings. Can you think of a reason why managed care organizations should not be asked to use this important tool?

2. A 2017 report by Johns Hopkins University and the Clinton Health Foundation included several recommendations for combating the opioid crisis. One of those was related to the ability of insurers to access PDMP data. The report recommends to (and I quote) "authorize third-party payers to access PDMP data with a plan for appropriate use and proper protections." Mr. Srivastava will your organization work with this committee to ensure that third-party payers have access to PDMP data in a way that meets proper privacy protections?

3. In testimony you suggest 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 better understand this concern, as my understanding is that actual fraudulent behavior would cause a pharmacy to be prosecuted by CMS and or state authorities. So is the concern that managed care plans have to take any pharmacy willing to accept the plan's contract, or the concern that pharmacies with problematic business patterns are not identified and pursed quick enough, or still get in due to network adequacy requirements? I ask this because we to ensure Medicaid programs have the right tools, but also that patients can access high quality providers and pharmacies of their choice.

4. In your testimony, Mr. Srivastava, you note that Magellan works with 80,000 behavioral health care providers nationwide. Mr. Guth's testimony highlights how in 2013, all nine types of behavioral health practitioners had shortages. So I am interested in hearing from you about how we address the supply of credential health care providers, given the demand the opioid crisis is placing on the health care system. You mentioned the idea of increased matching funds in Medicaid, but it's not clear to me that such an approach would be as effective as some might think. MACPAC's review of the primary care payment bump in the ACA concluded – and I quote – "there is not enough evidence to definitively determine whether the payment increase had an effect on provider participation or enrollee access to primary care in Medicaid." One of the bills before us contemplates understanding how Medicaid GME dollars are used, while another bill seeks to provide increased matching funds for some capacity building, but seems a bit vague and open-ended as to what it would actually fund. I would like each panelist to quickly explain two or three concrete actions Congress could take to ensure current providers are adequately trained and a couple of concrete actions to foster the development of more behavioral health providers.

5. 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?

6. 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?

7. 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?

8. 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?