Response of Sam K. Srivastava, CEO of Magellan Healthcare, Magellan Health, Inc.
Questions for the Record

May 15, 2018

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

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Committee on Energy and Commerce
Subcommittee on Health

Q1: The Centers for Medicare and Medicaid Services recently released its annual Drug Utilization Review report. 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?

As your question suggests, the Centers for Medicare & Medicaid Services (CMS) released in October 2017 the agency's federal fiscal year (FFY) 2016 *Medicaid Drug Utilization Review (DUR) State Comparison/Summary Report*, which found "[a]lmost all Medicaid agencies, except Florida, have a Lock-In or Patient Review and Restriction Program in which the state identifies potential fraud or misuse of controlled drugs by a beneficiary" for their Medicaid fee-for-service beneficiaries.[1,2] (The state of Florida does permit lock-in in Medicaid managed care, effective September 2016; *see* Footnote 2.) Provider- and pharmacy-assignment, or lock-in, strategies have a long history in Medicaid and, more recently, have begun to expand to other healthcare payers, including Medicare under the Comprehensive Addiction and Recovery Act of 2016.

While CMS's annual DUR report currently does not include information on provider- and pharmacy-assignment strategies within Medicaid managed care, a June 2017 analysis prepared by *Open Minds* reviewed 38 states with such strategies, finding 27 states require of, or make optional for, Medicaid managed care organizations (MCOs).[3] Specifically, the analysis found variation in whether implementation of such strategies was required of, or optional for, MCOs, whether the strategies were actively operating in a state, enrollment ranges, and criteria for enrollment. Similarly, the *Journal of Managed Care Pharmacy* published an abbreviated discussion of states' Medicaid lock-in strategies'

1. Centers for Medicaid & CHIP Services, Centers for Medicare & Medicaid Services, "Medicaid Drug Utilization Review State Comparison/Summary Report, FFY 2016 Annual Report: Prescription Drug Fee-For-Service Programs" (October 2017), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/2016-dur-summary-report.pdf. *See* Page ii for quoted language.
2. On Sep. 15, 2016, the Florida Agency for Health Care Administration issued Statewide Medicaid Managed Care (SMMC) Policy Transmittal no. 16-26, which advised Florida Medicaid MCOs "may have a pharmacy lock-in program that must be submitted in writing and approved by the Agency in advance of implementation." The transmittal also identified "the Agency's parameters for a pharmacy lock-in program." *See* http://ahca.myflorida.com/medicaid/statewide_mc/pdf/plan_comm/PT_16-26_Pharmacy_Lock-In_Policy_and_Guidelines_9-15-2016.pdf, and http://ahca.myflorida.com/medicaid/statewide_mc/pdf/plan_comm/PT_16-26_Pharmacy_Lock-In_Policy_and_Guidelines_Attachment_9-15-2016.pdf.
3. *Open Minds*, "Reference Guide: Use of Pharmacy Lock-in Programs by State Medicaid Programs" (June 2017), https://www.openminds.com/market-intelligence/reference-guide/pharmacy-lock-programs-state-medicaid/.

enrollment criteria, which also suggests significant variability between and amongst state Medicaid programs.[4]

In our experience with state Medicaid managed care programs, we view provider- and pharmacy-assignment strategies as an important component within a comprehensive suite of tools – based on both the evidence and best practice – to identify and prevent the inappropriate use/overuse of opioids, as well as to promote access to substance use treatment and services for beneficiaries with opioid use disorder (OUD). For example, for Florida's and Virginia's Medicaid managed care programs, Magellan's MCOs – Magellan Complete Care of Florida and Magellan Complete Care of Virginia – monitor opioid drug utilization through comprehensive member-identification programs that include provider- and pharmacy-assignment strategies. As discussed in my Written Statement (Page 29), we believe such strategies are an important tool within our DUR programs for Medicaid managed care beneficiaries:

> *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 [Centers for Disease Control and Prevention's] 2016* Guideline [for Prescribing Opioids for Chronic Pain[5]].

To my Written Statement, I also would add that – in addition to variability in states' Medicaid lock-in programs – one of the other issues we have seen is the impact of the Emergency Medical Treatment and Labor Act (EMTALA). Because of EMTALA, these strategies cannot account for inappropriate prescribing occurring through hospital emergency departments. To address this potential issue, some lock-in programs may attempt to assign a beneficiary to a hospital, but that introduces its own complexities and practicalities (e.g., multiple potential prescribers within the hospital system, role of the hospital's own pharmacy, etc.). As Congress considers legislative ideas for broadening and standardizing states' Medicaid lock-in programs, these additional issues could considered along with minimum enrollment criteria (e.g., Medicare criteria, above) and program parameters (e.g., beginning with what can be enforced across the board—assigning a beneficiary to a particularly pharmacy or pharmacy chain).

Q2: 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?

As discussed in my Written Statement (Pages 25-26), while state prescription drug monitoring programs (PDMPs) have been implemented in all but one state, only 31 states' Medicaid programs and Washington, D.C.'s program are authorized themselves to access the state PDMP. Moreover, in those that do extend access to the state's Medicaid program, MCOs, pharmacy benefit managers (PBMs), behavioral health organizations, administrative services organizations, and/or other sub-contractors to a state's Medicaid

4. Andrew W. Roberts, PharmD, and Asheley Cockrell Skinner, PhD, "Assessing the Present State and Potential of Medicaid Controlled Substance Lock-In Programs," *Journal of Managed Care Pharmacy* 20, no. 5 (May 2014): 439-446c, http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=18019. *See* Table 2 on Page 443.
5. 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.

programs – entities often administering Medicaid prescription drug benefits and substance use disorder (SUD) treatments and services – may not have access to PDMP data.

Our experience supporting state Medicaid managed care programs aligns with the findings of the Johns Hopkins University and Clinton Health Foundation report: third-party payers, including Medicaid MCOs and PBMs, often have no to limited ability to access PDMP data. In our March 2, 2018 response to the Committee's "Medicaid Managed Care Organization Survey," we provided detail on the opioids-related initiatives of Magellan Healthcare's MCOs.

In our experience, while Magellan's MCOs often have the ability to access the state's PDMP, the nature and extent of that access varies. For example, our Magellan Complete Care of Virginia MCO has the ability to access the commonwealth of Virginia's PDMP for the purposes of our patient utilization management and safety (PUMS) program rounds—a DUR program for Medicaid beneficiaries identified pursuant to Virginia Department of Medical Assistance Services (i.e., the Virginia Medicaid agency) specifications. In Florida, however, current state law does not allow practitioners in a Medicaid managed care setting to have access to the state's PDMP. Similarly, in Massachusetts, access to the commonwealth's PDMP requires a U.S. Drug Enforcement Agency (DEA) number be entered; pharmacists in a managed care setting would not have a DEA number.

For these reasons, in both my Written Statement and our March 2 survey response to the Committee, Magellan has recommended allowing public payers (including Medicaid and Medicaid), and their subcontractors (i.e., MCOs, PBMs, and the contractor's "pharmacy director (or a designee)"), the ability to access a state's PDMP. As we have demonstrated through our Magellan Complete Care of Virginia MCO, which has the ability both to (a) access the commonwealth's PDMP and (b) have our MCO's staff pharmacists and care managers check this PDMP, should Congress advance legislative ideas to "authorize third-party payers to access PDMP data," we will continue to ensure our access and that of our staff meets proper privacy protections.

Maintaining the protection and confidentiality of our members' health information and medical records – whether under the Health Insurance Portability and Accountability Act (HIPAA) or Title 42 of the Code of Federal Regulations (CFR) Part 2 – is an important responsibility Magellan takes extremely seriously. Much of what Magellan does on behalf of our members living with SUDs necessitates disclosing Part 2-covered, patient-identifying information within the healthcare system, including interfacing and interacting with providers, while protecting the privacy and confidentiality of these individuals. However, the vast majority of today's integrated care models – including those bringing together pharmacy data from state PDMPs with physical and behavioral healthcare services – rely on HIPAA-permissible disclosures and information sharing without the need for the individual's written consent to share relevant treatment details, provider by provider.

As discussed in detail in my Written Statement (Page 21-25):

> *Magellan strongly recommends the statute [at 42 CFR Part 2] be amended to permit the confidential 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 electronic medical records (EMRs).*

Q3: 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 want to ensure Medicaid programs have the right tools, but also that patients can access high quality providers and pharmacies of their choice.

In our experience, there often are substantial volumes of information from an array of sources related to potentially credible allegations of overprescribing which CMS, state authorities, health plans, and PBMs review and assess for potential action. Such processes appropriately take time to ensure allegations are credible and warrant exclusion. However, during this review period, the *states* have the ability to "place on hold" prescribers or pharmacies (even temporarily) within Medicaid, based on credible allegations of overprescribing (or fraud) rather than waiting for formal exclusions and while an investigation is ongoing.

Similarly, under Medicare Parts A and B, CMS may suspend payments pending an investigation of credible allegations of fraud, and this has contributed to efforts to prevent abusive practices. Under Part D, however, Medicare Advantage-Prescription Drug (MA-PD) plans and Prescription Drug Plans (PDPs) do not have this ability. In fact, MAPD plans and PDPs initially must pay claims even if there are major reasons to believe fraud is involved.

As discussed in my Written Statement (Pages 30-31):

> *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.*

Since my testimony and submission of this Written Statement, Representatives Tom MacArthur, Chris Collins, David Schweikert, Ann McLane Kuster, Earl Blumenauer, and Paul Tonko introduced (on May 3) H.R. 5676, which would authorize the suspension of payments by Medicare PDPs and MA-PD plans pending investigations of credible allegations of fraud by pharmacies. We view this legislation's introduction as a positive development.

Q4: 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.

In addition to the October 2014 findings of the Medicaid and CHIP Payment and Access Commission (MACPAC), the Urban Institute – in their review of various evaluations – also found "[i]nitial evidence is mixed on whether the increase in primary care fees, or 'fee bump,' successfully increased access to

primary care for Medicaid enrollees."[6] The Urban Institute review, however, accompanied its own analysis of the payment bump's impact on the Medicaid-to-Medicare primary care fee index. In their discussion of the fee index analysis, they note "that when the temporary federal policy expired, many states continued to pay higher fees for primary care than they did in 2012, suggesting that *even a temporary federal policy had lasting effects on some states' approaches to Medicaid reimbursement*" (emphasis added). A 2017 research report by the RAND Corporation also examined the primary care payment bump, finding the effect on physician participation was dampened because "participation was already high before the policy was rolled out."[7] The RAND report specifically mentioned stakeholders from Kansas, Nebraska, and New Jersey sharing this interpretation, with stakeholders in Florida suggesting the policy's impact was limited because it did not address their "biggest… issue": "specialist participation in the Medicaid program."[8]

We share these analyses with the Committee because current Medicaid participation rates for SUD treatment providers may be very different from primary care physicians (PCPs) and specialists. In 2015, 70 percent of all office-based physicians accepted new Medicaid patients and, in 2011-12 (pre-payment bump), two-thirds of PCPs and 72 percent of specialists participated in Medicaid.[9,10] According to a draft chapter for MACPAC's June 2018 Report to Congress, staff estimate only 60 percent of counties have at least one outpatient SUD facility that accepts Medicaid and 62 percent of SUD facilities participate in Medicaid, with ranges from 29 percent (California) to 91 percent (Vermont).[11]

Unlike with pre-payment bump and contemporary PCP participation in the Medicaid program, as well as contemporary specialists' participation, SUD provider participation in Medicaid is not "already high." Even a temporary federal policy may have a lasting effect on SUD provider participation in Medicaid. Further, such a policy could compliment other legislative ideas for increasing high-quality SUD provider participation in Medicaid. For example, increased matching funds could be tied to – rather than an across-the-board payment bump – specific behavioral health workforce providers/provider types (1) with low participation in Medicaid and (2) whom have attained accreditation, certification, or other training/commitment in their practice to adhere to evidence-based treatment and services.

In addition to this legislative idea of increased matching funds for increasing SUD treatment provider participation in Medicaid, my Written Statement (Pages 17-21) outlined nine specific opportunities for Congressional action on provider training (no. 7) and the behavioral health workforce (nos. 1-6 and 8). Here we reiterate these and offer additional ideas to ensure physicians and other providers are better prepared to prevent and respond to opioid misuse and to foster the behavioral health workforce:

6. Stephen Zuckerman, Laura Skopec, Marni Epstein, "Medicaid Physician Fees after the ACA Primary Care Fee Bump" (March 5, 2017), https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump/view/full_report. *See* Page 7.
7. Justin W. Timbie, Christine Buttorf, Virginia I. Kotzias, Spencer R. Case, and Ammarah Mahmud, "Research Report: Examining the Implementation of the Medicaid Primary Care Payment Increase" (2017), RAND Corporation: Santa Monica, Calif., http://www.rand.org/t/RR1802. *See* Page 25.
8. RAND Corporation (2017), Page 26.
9. Esther Hing, MPH, Sandra L. Decker, PhD, and Eric Jamoom, PhD, MPH, MS, "Acceptance of New Patients with Public and Private Insurance by Office-based Physicians: United States, 2013," National Center on Health Statistics Data Brief no. 195 (March 2015), https://www.cdc.gov/nchs/data/databriefs/db195.pdf.
10 . Sandra L. Decker, "Two-third of Primary Care Physicians Accepted New Medicaid Patients in 2011-12: A Baseline to Measure Future Acceptance Rates" *Health Affairs* 32, no. 7 (July 2013), https://doi.org/10.1377/hlthaff.2013.0361.
11. Erin McMullen, MACPAC, "Access to Substance Use Disorder Treatment in Medicaid: Draft Chapter" (April 19, 2018), https://www.macpac.gov/public_meeting/april-2018-macpac-public-meeting/.

Enhancing Physician and Provider Training

(a) *Reducing the social stigma associated with OUD and the use of MAT,* including by reframing OUD and other SUDs as chronic conditions requiring ongoing treatment and MAT and psychosocial interventions as effective, evidence-based treatment strategies. As the National Governors Association also has suggested, a CMS-led, multi-stakeholder awareness campaign may include: information on the risks associated with opioids and step-by-step directions for taking these prescription drugs that minimize the chances of developing OUD or overdosing; and, referrals and other resources for individuals with OUD and other SUDs seeking treatment who may not have regular access to, or ability to afford, health insurance.

(b) *Enhancing provider knowledge of treatment modalities and available resources.* As discussed in my Written Statement (Pages 14-15):

> *[M]any 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 OUD and other SUDs in need of treatment. Social stigma towards SUDs and MAT as a treatment modality is also a factor… [E]ducating 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. 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.*

Specifically, Congress may encourage CMS to partner with the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), and medical and professional societies to increase provider:

(1) comfort and knowledge of the proven effectiveness of MAT;
(2) familiarity with evidence-based protocols for treatment;
(3) training in the use of MAT and psychosocial interventions; and,
(4) 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.

Building a High-quality Behavioral Health Workforce

(c) *Supporting the delivery of medication assisted treatment (MAT) through telemedicine*. As discussed in my Written Statement (Page 17), telemedicine may be best suited to improve access to persons living in geographic areas away from SUD treatment providers, and may expand access beyond traditional settings of care. Policies and procedures can be developed to ensure patient safety, delivery of prescriptions for MAT, patients' connection to psychosocial interventions, and to ensure a system-wide outlook where inclusive of points of access across the full continuum of care over time.

(d) *Permanently expanding the pool of qualified buprenorphine prescribers* by making buprenorphine waivers available to qualified advanced practice registered nurses (APRNs) with prescriptive privileges, such as nurse practitioners, clinical nurse specialists, certified nurse-

midwives, certified registered nurse anesthetists, and others (as noted in my Written Statement (Page 17)). (The current law sunsets these privileges Oct. 1, 2021.) A systematic review of the literature on care provided by APRNs concluded these healthcare professionals provide safe and effective quality care in numerous settings, and that, in partnership with physicians and other healthcare providers, contribute to health promotion.[12]

(e) *Expanding MAT patient panel maximums for APRNs beyond the 30-patient limit* for up to 100 patients with OUD. As part of such an expansion (and the permanent change recommended in (d), above), we recognize inappropriate prescribing is always possible. As for other programs and initiatives, there should be a role for audit and oversight of all DEA-waived practitioners.

(f) *Exploring value-based payment (VBP) initiatives* to incent Medicare, Medicaid, Indian Health Services, Veterans Administration, and federally qualified healthcare providers to (a) increase utilization of and access to MAT to treat OUD by providing the appropriate financial support to enable clinicians and care managers to successfully collaborate to treat OUD comprehensively; (b) broaden the coordinated delivery of medication, psychological, and social services, including therapy and psychosocial interventions; and (c) increase the proportion of individuals living with OUD who access and retain treatment. Such VBP initiatives for behavioral health could include emerging payment models, such as the American Society of Addiction Medicine's Patient-Centered Opioid Addiction Treatment model.

(g) *Advancing a nationally recognized mechanism to ensure accreditation of SUD treatment and services providers*, with the future potential to include Center of Excellence (COE) designations and to limit federal reimbursement to accredited providers. Such COE designations also could tie to VBP initiatives.

Q5: 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?

In my Written Statement and our March 2, 2018 response to the Committee's "Medicaid Managed Care Organization Survey," we discuss our experience using states' PDMPs as part of our DUR programs for Medicaid managed care beneficiaries. Both also discuss current barriers to the fuller effectiveness of these information databases. Specifically, I suggest in my Written Statement (Pages 25-26) that:

> *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 [information technology] systems or into professionals' and paraprofessionals', including prescribers', routines and patient protocols. 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.*

To address these unintended limitations on the usefulness of PDMPs, my Written Statement (Page 26) recommends Congress consider the following ideas:

> *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.,*

12. R.P. Newhouse, J. Stanik Hutt, K.M. White, et al. "Advanced practice nurse outcomes 1990–2008: a systematic review," *Nursing Economics* no. 29 (2011): 230-250.

increased FMAP for expenditures related to improving the PDMP in line with such activities) for encouraging states to[:]

- *(a) 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;*
- *(b) 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;*
- *(c) ensure data accuracy and availability in as close to real time as is feasible;*
- *(d) better integrate across the country by ensuring state PDMP interoperability with other states;*
- *(e) improve completeness, workflow integration, and interoperability of PDMP reports into EMRs and [health information exchanges] to streamline provider[, dispenser,] 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;*
- *(f) 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,*
- *(g) make PDMPs easier to use and report into by allowing prescribers to establish delegate accounts.*

Q6: Numerous studies have found that Medicaid enrollees have excessive burdens of chronic pain and are at a much higher risk of SUDs 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?

Yes. In our review of the (a) Medicaid Providers and Pharmacists Required to Note Experiences in Record Systems to Help In-need Patients Act (Medicaid PARTNERSHIP Act) of 2018, (b) the Medicaid Drug Review, Utilization, Good Governance Improvement Act (Medicaid DRUG Improvement Act) of 2018, and (c) the Medicaid Pharmacy Home Act of 2018, our initial takeaway is they point in the right direction and the Committee is on the right track. We need to expand capacity for treatment and recovery services and develop programs for at-risk populations that limit access to these highly addictive drugs.

To further support the Committee's important work, we have specific feedback on each of the bills that we hope is helpful:

(a) *Medicaid PARTNERSHIP Act:* This bill builds on the constructive efforts of states to implement and promote the use of PDMPs and of state Medicaid programs, Medicaid MCOs, and Medicaid PBMs to use these important information databases, where possible. We support this bill. Because the definition of "managed care entity" differs state-by-state, we recommend the bill include explicit language extending PDMP access to Medicaid MCOs and PBMs.

(b) *Medicaid DRUG Improvement Act:* This bill builds on the constructive efforts of state Medicaid programs, MCOs and other health plans, and PBMs to implement DUR programs within Medicaid managed care, Medicare, and commercial plans. We support this bill. We suggest clarification may be needed, however, to reflect current rules that disallow the refill of schedule II

opioids (rather, to limit second fills instead). Further, we recommend any requirement for a claims review automated process when opioids are prescribed concurrently with other prescription drugs be evidence based. For example, in Magellan's experience serving individuals with complex healthcare needs, the combination (or "polypharmacy") of opioids and HIV treatment drugs is neither uncommon nor inappropriate, particularly dependent on the stage of HIV (i.e., AIDS).

(c) *Medicaid Pharmacy Home Act:* This bill builds on the constructive efforts of state Medicaid programs and Medicaid MCOs to implement provider- and pharmacy-assignment strategies within Medicaid. We support this bill. We suggest such strategies, however, can be hampered if the MCOs and/or PBMs supporting them do not have access to the state's PDMP.

These draft bills are critically important components to developing a comprehensive response to this crisis, and Magellan remains committed to supporting the Committee's legislative efforts.

Q7: 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?

Yes. Medicaid and the Children's Health Insurance Program are significant healthcare purchasers and their staffs – similar to the Medicare program, and the professional staff within CMS – oversee healthcare coverage, access, and quality of care for a substantial number of Americans. As MACPAC noted in its June 2014 Report to Congress, "[t]he demands on state Medicaid agencies are extensive and diverse and continue to grow as these programs increase in size and scope and seek to increase value and accountability through more sophisticated purchasing strategies."[13] Specific to the Medicaid HUMAN CAPITAL Act, the report suggests "[s]tate Medicaid agencies need high level analytic, financial, and clinical expertise to implement and oversee these modernized systems," and the same is true for specific opioid-mitigation strategies as for these programs overall.[14]

To best support these important programs, as well as specific strategies relating to the opioid crisis, it is important state Medicaid agencies are able to attract and retain high-quality staff.

Q8: 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?

13. MACPAC, *Report to the Congress on Medicaid and CHIP*, "Chapter 4: Building Capacity to Administer Medicaid and CHIP," Page 171 (June 2014), https://www.macpac.gov/wp-content/uploads/2015/01/Building_Capacity_to_Administer_Medicaid_and_CHIP.pdf.
14. MACPAC (June 2014), Page 179.

We support Congressional action and legislative ideas to expand capacity for SUD treatment and recovery services in Medicaid and to develop programs for at-risk populations that limit access to these highly addictive drugs. Specific to increasing SUD provider capacity in Medicaid, and as I note in my response to Q4, above, we remain concerned that lower Medicaid provider rates reduce SUD provider participation and capacity. To add color to our concerns, in a forthcoming Report to the Congress, MACPAC is anticipated to share estimates that only 60 percent of counties have at least one outpatient SUD facility that accepts Medicaid and 62 percent of SUD facilities participate in Medicaid, with participation ranges as low as 29 percent to 91 percent.[15]

While Congress and various federal agencies – such as HRSA, SAMHSA, and CDC – have invested meaningfully in provider capacity development programs, including through the Graduate Medical Education (GME) program, within Medicaid we have a confluence of two challenges: (1) the size of the behavioral health workforce (or provider capacity) and (2) participation in the Medicaid program, specifically. We believe the draft bill (i.e., "to amend title XIX of the Social Security Act to provide for a demonstration project to increase substance use provider capacity under the Medicaid program") begins to address the need to increase capacity and strengthen the behavioral health workforce specific to Medicaid. To further support the goals identified (i.e., (1) and (2), above), my Written Statement (Pages 17-21) and Pages 4-6 herein have outlined additional legislative ideas.

15. MACPAC (April 19, 2018).