

ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

April 9, 2018

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on “Combatting the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients”

On **Wednesday, April 11th, at 2:15 p.m. in room 2123 of the Rayburn House Office Building**, the Subcommittee will hold a legislative hearing titled “Combatting the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients.” Following the first panel on Wednesday, the Subcommittee will reconvene on Thursday, April 12th, at 10:15 a.m. in room 2322 of the Rayburn House Office Building for a second witness panel. The hearing will examine the following 34 bills and discussion drafts across Medicaid and Medicare:

Medicaid

- A. Discussion Draft of H.R. ____, Medicaid Pharmacy Home Act
- B. Discussion Draft of H.R. ____, Medicaid Drug Review, Utilization, Good Governance Improvement Act (Medicaid DRUG Improvement Act)
- C. Discussion Draft of H.R. ____, Medicaid Providers and Pharmacists Required to Note Experiences in Record Systems to Help In-need Patients Act (The Medicaid PARTNERSHIP Act)
- D. Discussion Draft of H.R. ____, Medicaid Incentives for Health Homes to Treat Substance Use Disorder
- E. Discussion Draft of H.R. ____, Medicaid Institutes for Mental Disease Are Decisive in Delivering Inpatient Treatment for Individuals but Opportunities for Needed Access are Limited without Information Needed About Facility Obligations (The Medicaid IMD ADDITIONAL INFO Act)
- F. Discussion Draft of H.R. ____, Improving Medicaid Data Timeliness Act
- G. Discussion Draft of H.R. ____, Improving the Transparency for Graduate Medical Education Funded by Medicaid Act

- H. Discussion Draft of H.R. ____, Medicaid Helping Unite Managers who have Abilities with Novel Chances to Activate the Possibilities of Innovation, Transformation, And Leadership Act (Medicaid HUMAN CAPITAL Act)
- I. Discussion Draft of H.R. ____, Provide IMD Services Up to 90 Days for Medicaid Beneficiaries with SUD
- J. Discussion Draft of H.R. ____, Require HHS to act within a certain timeframe in implementing GAO's recommendation for HHS to execute a strategy related to infants with neonatal abstinence syndrome
- K. Discussion Draft of H.R. ____, Creation of a demonstration project
- L. Discussion Draft of H.R. ____, Require State Medicaid Programs To Report On The 10 Behavioral Health Measures That Are Included In CMS' 2018 Core Set Of Adult Health Care Quality Measures For Medicaid
- M. H.R. 4998, Health Insurance For Former Foster Youth Act
- N. H.R. 1925, At-Risk Youth Medicaid Protection Act of 2017
- O. H.R. 4005, Medicaid Re-entry Act
- P. H.R. 3192, CHIP Mental Health Parity Act
- Q. Discussion Draft of H.R. ____, To amend title XIX of the Social Security Act to provide for Medicaid coverage protections for pregnant and post-partum women while receiving inpatient treatment for substance use disorder (Mom IMD Act)

Medicare Part B

- R. H.R. 3331, To amend title XI of the Social Security Act to promote testing of incentive payments for behavioral health providers for adoption and use of certified electronic health record technology
- S. Discussion Draft of H.R. ____, Incentivizing Non-Opioid Drugs
- T. Discussion Draft of H.R. ____, CMS Action Plan
- U. Discussion Draft of H.R. ____, Initial Pain Assessment
- V. Discussion Draft of H.R. ____, Access to Telehealth Services for Opioid Use Disorders Act
- W. Discussion Draft of H.R. ____, Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act
- X. Discussion Draft of H.R. ____, Adding Resources on Non-Opioid Alternatives to the Medicare Handbook
- Y. Discussion Draft of H.R. ____, Post-Surgical Injections as an Opioids Alternative

Medicare Part D

- Z. H.R. 3528, Every Prescription Conveyed Securely Act
- AA. Discussion Draft of H.R. ____, Mandatory Lock-In
- BB. H.R. 4841. Standardizing Electronic Prior Authorization for Safe Prescribing Act
- CC. Discussion Draft of H.R. ____, Beneficiary Education
- DD. Discussion Draft of H.R. ____, Evaluating Abuse Deterrent Formulations in Part D
- EE. Discussion Draft of H.R. ____, Prescriber Notification
- FF. Discussion Draft of H.R. ____, Prescriber Education

- GG. Discussion Draft of H.R. _____, Medication Therapy Management (MTM) Expansion
HH. Discussion Draft of H.R. _____, CMS/Plan Sharing

I. BACKGROUND AND OVERVIEW

A. MEDICAID COVERAGE AND FINANCING OF OPIOID TREATMENT

Medicaid is the nation's largest payer for behavioral health services, providing comprehensive coverage for people of all ages with substance use disorders (SUDs). The need for Medicaid in treating non-elderly adults with SUD is especially pronounced even though persons of all ages can suffer from SUDs. Overall, Medicaid covers nearly four in ten nonelderly adults with an opioid addiction.¹ Nearly 12 percent of adults enrolled in Medicaid have a SUD.² Adults with Medicaid are more likely than other adults to receive SUD treatment.³ Both states and the federal government have undertaken extensive efforts over the past several years to reorganize the SUD delivery system to better integrate the full continuum of care.

Medicaid also plays a critical role for children either suffering from SUD or born with Neonatal Abstinence Syndrome (NAS). Medicaid covered more than 80 percent of NAS births nationwide in 2014.⁴ The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate mental health and SUD services.⁵ For states that operate separate CHIP programs for children and infants, SUD treatment – though offered – is not a mandated benefit under the statute.

¹ Kaiser Family Foundation, *Medicaid's Role in Addressing the Opioid Epidemic* (Feb. 2018) (https://kaiserfamilyfoundation.files.wordpress.com/2018/02/medicaid_s-role-in-addressing-the-opioid-epidemic-feb-2018-update.png).

² Center for Budget and Policy Priorities, *Medicaid works for People with Substance Use Disorders* (Jan. 2018) (<https://www.cbpp.org/research/health/medicaid-works-for-people-with-substance-use-disorders>).

³ *Id.*

⁴ Healthcare Finance, *Opioid Epidemic: Medicaid spent \$2 Billion Excess Over a Decade on Neonatal Abstinence Syndrome* (Mar. 2018) (<http://www.healthcarefinancenews.com/news/opioid-epidemic-medicare-spent-2-billion-excess-over-decade-neonatal-abstinence-syndrome>).

⁵ Centers for Medicare and Medicaid Services, *Early and Periodic Screening Diagnostic, and Treatment* (<https://www.medicare.gov/medicaid/benefits/epsdt/index.html>).

Prior to Medicaid expansion in 2013, CMS reported that an estimated 12 percent of adult Medicaid beneficiaries ages 18-64 had a SUD⁶, and that an estimated 15 percent of uninsured individuals who could be newly eligible for Medicaid coverage ACA had a SUD.⁷ State Medicaid programs also specifically reduce barriers to and provide coverage for a range of evidence-based SUD treatment services, including medication-assisted treatment (MAT).⁸ All states cover buprenorphine and the overwhelming majority of states cover all three, in addition to the behavioral therapy necessary for effective MAT.⁹ Spending for MAT in state Medicaid programs has sharply increased. Between 2011 and 2016, Medicaid spending on opioid use disorder (OUD) treatment prescriptions for buprenorphine, naltrexone, and naloxone increased 136 percent.¹⁰

Medicaid can be a sustainable funding source for providers, as opposed to capped, short-term grant funding. Medicaid's role since expansion with respect to treatment of adults with SUD has also allowed providers who have not historically been able to participate in Medicaid to expand their capacity to treat individuals with SUD. However, state Medicaid programs have struggled in some cases with the lack of resources needed to rapidly expand capacity to meet demand for services across the continuum of care.

B. STATE SECTION 1115 WAIVERS FOR SUD TREATMENT

In July 2015, the Centers for Medicare and Medicaid Services (CMS) issued guidance that outlined new service delivery opportunities for individuals with a SUD.¹¹ CMS articulated a policy to support 1115 demonstrations ("waivers") for states pursuing "broad and deep system transformations" in the area of SUD. Medicaid's Innovation Accelerator Program (IAP) works

⁶ Substance Abuse and Mental Health Services Administration, *Behavioral Health Treatment Needs Assessment Toolkit for States* (2013) (<http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf>).

⁷ Susan H. Busch, et al., *Characteristics of Adults With Substance Use Disorders Expected to Be Eligible for Medicaid Under the ACA*, Psychiatric Services (2013).

⁸ Senate Joint Economic Committee, *Hearing on Economic Aspects of the Opioid Crisis*, 115th Cong., Testimony of Richard G. Frank, Margaret T. Morris Professor of Health Economics, Harvard Medical School (June 2017) (https://www.jec.senate.gov/public/_cache/files/3f089ec3-3765-44e7-a612-cbfaa765232b/dr.-frank---testimony.pdf).

⁹ The American Society of Addiction Medicine, *Advancing Access to Addiction Medications* (2013) (https://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final).

¹⁰ Urban Institute, *Rapid Growth in Medicaid Spending on Medications to Treat Opioid Use Disorder and Overdose* (June 2017) (https://www.urban.org/sites/default/files/publication/91521/2001386-rapid-growth-in-medicaid-spending-on-medications-to-treat-opioid-use-disorder-and-overdose_3.pdf).

¹¹ Center for Medicaid and CHIP Services, Letter to State Medicaid Directors, *New Service Delivery Opportunities for Individuals with a Substance use Disorder* (July 27, 2015) (<https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>).

with state Medicaid agencies interested in strategic design support to develop their section 1115 SUD demonstration proposals and implementation plans. The Trump Administration reissued similar guidance in 2017, reaffirming the agency’s commitment to SUD waivers. Nearly 20 state Medicaid programs have approved SUD waivers or pending SUD waiver requests before CMS.

SUD waiver states are providing services such as inpatient treatment or short-term residential treatment, and innovative evidence-based services like peer supports. These waiver states are also providing wraparound supports to increase the impact of treatment.¹² For example, West Virginia’s waiver includes a waiver of the institution for mental diseases (IMD) exclusion, all forms of MAT treatment, peer recovery supports, withdrawal management, and a comprehensive outpatient network of services and short and longer-term residential treatment. West Virginia also introduced new programs to improve quality and increase care coordination, and it has a strong focus on concurrent treatment for postpartum women and their infants.

C. TREATMENT CAPACITY FOR SUD

Although Medicaid provides rich benefits for a population in need of SUD or opioid use disorder (OUD) treatment, provider capacity is lacking. A 2015 Department of Health and Human Services (HHS) report¹³ and a 2013 Substance Abuse and Mental Health Services Administration (SAMHSA) report¹⁴ to Congress highlighted key challenges for Medicaid and SUD treatment.

Virtually all counties in the country, especially those with high numbers of Medicaid beneficiaries, still lack the necessary outpatient and inpatient behavioral health workforce capacity necessary for SUD treatment. In a November 2017 letter to State Medicaid Directors, CMS cited that “40 percent of counties in the U.S. do not have an addiction treatment facility that provides outpatient care and accepts Medicaid,” which was “most prevalent in rural counties in Southern and Midwestern states and in areas with a higher proportion of racial and ethnic minorities.”¹⁵ To fully realize the promise of increased access, many providers who treat SUDs

¹² Center on Budget and Policy Priorities, *Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest Data Show* (Feb. 2018) (<https://www.cbpp.org/research/health/medicaid-expansion-dramatically-increased-coverage-for-people-with-opioid-use>).

¹³ Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Examining Substance Use Disorder Treatment Demand and Provider Capacity in a Changing Health Care System: Initial Findings Report* (Sep. 30, 2015) (<https://aspe.hhs.gov/report/examining-substance-use-disorder-treatment-demand-and-provider-capacity-changing-health-care-system-initial-findings-report>).

¹⁴ Substance Abuse and Mental Health Services Administration, *Report to Congress on the Nation’s Substance Abuse and Mental Health Workforce Issues* (Jan. 2013) (<https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>).

¹⁵ Center for Medicaid and CHIP Services, Letter to State Medicaid Directors, *Strategies to Address the Opioid Epidemic* (Nov. 1, 2017) (<https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>).

need help from states to meet Medicaid participation requirements. States also need to invest, according to CMS, in related efforts necessary to improve staffing and technological capacity.

D. MEDICAID IMD EXCLUSION

The Medicaid IMD exclusion prohibits federal financial participation (FFP) for any services provided to otherwise eligible individuals specifically between ages 21 and 64, in an IMD.¹⁶ The exclusion has existed since the inception of Medicaid. An IMD is an inpatient facility that treats primarily behavioral health needs with more than 16 beds. The law has been interpreted to include inpatient SUD treatment facilities as IMDs,¹⁷ and amended over time to allow for certain populations to receive IMD services (e.g. children under 21, adults 65 and over). The rationale for the exclusion includes the states' historic role as the primary payer for inpatient behavioral health services, the history of de-institutionalization of behavioral and mental health services, and the immense Medicaid costs associated with expanding FFP for inpatient psychiatric care.¹⁸

CMS has exercised flexibility with respect to the IMD exclusion, particularly as it relates to SUD, prioritizing IMDs for SUD as one part of the continuum of care. The agency has deliberately emphasized an equal investment in community resources while also recognizing that a comprehensive continuum of care, including treatment and recovery for individuals with SUD, requires access to inpatient and short-term residential levels of care. States have worked to provide IMD services to excluded populations for SUD through their section 1115 waivers.

E. SENIORS WITH SUD OR OUD

Opioid misuse among older adults is a significant and growing problem. According to SAMHSA, more than 1 million individuals aged 65 years and older had a SUD in 2014, including 161,000 with an illicit drug use disorder.¹⁹ Data suggest specifically that opioid misuse among adults age 50 and older in 2014, was higher than all years between 2002 and 2011.²⁰ Both Medicare Parts B and D cover SUD treatment services, including outpatient or office-based medications and behavioral health services. However, there are significant gaps in the Medicare

¹⁶ Section 1905(a)(B) of the Social Security Act.

¹⁷ Legal Action Center, *The Medicaid IMD Exclusion: An Overview and Opportunities for Reform* (2014) (https://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf).

¹⁸ Medicaid and CHIP Payment and Access Commission, *The Medicaid Institution for Mental Diseases (IMD) Exclusion* (Mar. 31, 2016) (<https://www.macpac.gov/wp-content/uploads/2016/03/The-Medicaid-Institution-for-Mental-Diseases-IMD-Exclusion.pdf>).

¹⁹ Substance Abuse and Mental Health Services Administration, *A day in the Life of Older Adults: Substance Use Facts* (May 11, 2017) (https://www.samhsa.gov/data/sites/default/files/report_2792/ShortReport-2792.html).

²⁰ Substance Abuse and Mental Health Services Administration, *Opioid Misuse Increases Among Older Adults* (July 25, 2017) (https://www.samhsa.gov/data/sites/default/files/report_3186/Spotlight-3186.html).

benefit: for instance, Medicare does not cover substance abuse treatment at Opioid Treatment Programs or methadone clinics.

Medicare beneficiaries may be vulnerable to over-prescribing, especially because seniors are more likely to report chronic pain and have adverse interactions with other prescription medications. An analysis of Medicare Part D data by the Department of Health and Human Services Office of the Inspector General (HHS OIG) revealed that more than 500,000 Medicare Part D beneficiaries received high amounts of opioids in 2016, with the average dose far exceeding the manufacturer's recommended amount.²¹ Roughly one-third of beneficiaries enrolled in Medicare's drug program (Part D) received an opioid prescription in 2016. Furthermore, among Medicare beneficiaries under age 65 who qualify on the basis of disability, nearly 50 percent are receiving opioid prescriptions.²²

II. LEGISLATION AND DISCUSSION DRAFTS

A. DISCUSSION DRAFT OF H.R. _____, MEDICAID PHARMACY HOME ACT

The majority of Medicaid programs use patient review and restriction (PRR) programs, also referred to as "Medicaid lock-in" programs, to prevent so-called pharmacy and doctor shopping. As of November 2015, Medicaid programs in 48 states and the District of Columbia utilized PRR.²³ The programs assign at-risk Medicaid beneficiaries to certain pharmacies and prescribers for prescriptions. Currently, at-risk patients are identified based on a combination of criteria, unique to each state Medicaid program, which usually includes numbers of prescriptions and pharmacies a patient has visited to obtain controlled substance prescriptions.²⁴

The discussion draft would require all states to have a lock-in program that identifies at-risk Medicaid beneficiaries based on certain criteria and sets limits on the number of prescribers and dispensers they may utilize, whether under a fee-for-service or managed care arrangement. States would be subject to a Federal Medical Assistance Percentages (FMAP) penalty for noncompliance by January 2019.

B. DISCUSSION DRAFT OF H.R. _____, MEDICAID DRUG IMPROVEMENT ACT

²¹ Office of Inspector General, Department of Health and Human Services, *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing* (July 11, 2017) (<https://oig.hhs.gov/oei/reports/oei-02-17-00250.asp>).

²² *Id.*

²³ The Medicaid and CHIP Payment and Access Commission, *Medicaid and the Opioid Epidemic* (June 2017) (<https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf>).

²⁴ *Id.*

Medicaid drug utilization review (DUR) is a two-phase process that is conducted by the Medicaid state agencies. In the first phase (prospective DUR), the state's Medicaid agency's electronic monitoring system screens prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse. The second phase (retrospective DUR) involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care, and implements corrective action when needed.²⁵ DUR can also be conducted concurrently, and when inappropriate practices are identified, pharmacists, prescribers, and other members of the health team modify and improve drug therapy practices. Retrospective and concurrent DUR measures can be used to identify potentially inappropriate prescribing practices.²⁶

On an annual basis, states are required to report on their state's prescribing habits, cost savings generated from their DUR programs and their program's operations, including adoption of new innovative DUR practices via the Medicaid Drug Utilization Review Annual Report.

The discussion draft requires all state Medicaid programs to use DUR activities in both fee-for-service and managed care with respect to opioids prescribing, monitoring of antipsychotics, and specific monitoring of concurrent prescribing of opioids and certain conditions, including HIV/AIDS, benzodiazepines, and antipsychotics. States will be required to have state-determined limitations in place for opioid refills, a program in place to monitor antipsychotic prescribing for children, and at least one buprenorphine/naloxone combination drug on the Medicaid drug formulary. States could be subject to FMAP penalties for noncompliance as of January 2019.

C. DISCUSSION DRAFT OF H.R. _____, MEDICAID PARTNERSHIP ACT

All states except for Missouri now have prescription drug monitoring programs (PDMPs) to track dispensing of controlled substances, including opioids. Such programs are most commonly operated by state boards of pharmacy, not Medicaid. As of December 2014, only 31 state Medicaid programs had access to their state's PDMP. Lack of data sharing on a real-time basis between a state's PDMP and a state's Medicaid program has been cited as a significant issue that allows for continued misuse. A recent study found that between 2011 and 2014, the introduction of state mandates for prescribers to register with or use their state's PDMP was

²⁵ Center for Medicare and Medicaid Services, *Drug Utilization Review* (<https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/index.html>).

²⁶ Center for Medicare and Medicaid Services, CMCS Informational Bulletin, *Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction* (Jan. 28, 2016) (<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/cmcs-cib-1-28-16.pdf>).

associated with a 9–10 percent reduction in the number of Schedule II opioid prescriptions Medicaid enrollees received as well as Medicaid spending on these prescriptions.²⁷

The discussion draft would require the Medicaid program in each state to integrate PDMP usage into a Medicaid provider’s (including pharmacists) clinical workflow. The bill establishes standard criteria that a PDMP must meet to be counted as a qualified PDMP for purposes of the Medicaid program. The bill would require states to report to CMS on how their PDMPs are working and the number of covered providers who are using the PDMPs, as well as statewide trends in controlled substance utilization. This legislation includes a FMAP implementation incentive that would be given to states at the Secretary’s discretion, and a FMAP penalty for noncompliance.

D. DISCUSSION DRAFT OF H.R. ____, MEDICAID INCENTIVES FOR HEALTH HOMES TO TREAT SUBSTANCE USE DISORDER

The ACA created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. States receive a 90 percent matching rate for eight quarters to address the startup costs and investments needed to create a successful health home. Under the statute, states are able to specifically create SUD health homes, as well as behavioral health homes. However, despite the success of the model, only a handful of states so far have targeted their health homes specifically to SUD. The discussion draft would amend current law to incentivize states to create health homes for Medicaid beneficiaries with SUD. Specifically, the bill would extend the enhanced match from eight quarters to 12 quarters so long as states meet quality, cost, and access targets.

E. DISCUSSION DRAFT OF H.R. ____, MEDICAID IMD ADDITIONAL INFO ACT

The Medicaid IMD exclusion is waived through various mechanisms for both SUD and mental health, depending on the state. However, many of the financing mechanisms for IMD are recent and the full scope of changes made to the delivery system by the reintegration of IMDs is not known. The discussion draft would direct the Medicaid and CHIP Payment and Access Commission (MACPAC) to conduct a study on IMDs. The study will report on the requirements, standards, and oversight that State Medicaid programs have for IMDs. MACPAC, considering input from stakeholders, will summarize the findings and make recommendations on improvements and best practices. The report is due January 2020.

F. DISCUSSION DRAFT OF H.R. ____, IMPROVING MEDICAID DATA TIMELINESS ACT

²⁷ The Medicaid and CHIP Payment and Access Commission, *Medicaid and the Opioid Epidemic* (June 2017) (<https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf>).

The discussion draft would reduce the filing window for Medicaid claims from two years to one year. Currently, under a provision of law added in 1980, it is possible to submit claims for up to two years after the date of service.

G. DISCUSSION DRAFT OF H.R. ____, IMPROVING THE TRANSPARENCY FOR GRADUATE MEDICAL EDUCATION FUNDED BY MEDICAID ACT

In 2015, the federal government spent \$2.3 billion on Graduate Medical Education (GME) through the Medicaid program out of the estimated \$14.5 billion spent overall on GME across all federal health programs. The discussion draft would require state Medicaid programs to report to CMS information on how Medicaid GME funds are being used to support physician training. Additionally, the state Medicaid program is required to report specific information on how physicians are trained in specialties that are essential in the opioid crisis (i.e., psychiatry, addiction medicine, etc.) and how GME recipients are using Medicaid funds to train physicians on SUD. ²⁸

H. DISCUSSION DRAFT OF H.R. ____, MEDICAID HUMAN CAPITAL ACT

The discussion draft would provide enhanced FMAP to use toward hiring and retaining senior leadership for Medicaid programs, who meet certain quantifiable professional standards. This policy change improves the ability of state Medicaid programs to recruit and retain high caliber private sector talent to manage state Medicaid programs, and will help reduce the short duration of most Medicaid directors (which averages about 18 months). The enhanced funding will sunset in 2026.

I. DISCUSSION DRAFT OF H.R. ____, PROVIDE IMD SERVICES UP TO 90 DAYS FOR MEDICAID BENEFICIARIES WITH SUD

The discussion draft would allow states to receive federal Medicaid matching dollars for up to a total of 90 days per year for services in an IMD for Medicaid beneficiaries with a SUD. Beneficiaries would need to be assessed after the first 30 days to determine if continued care (up to 60 more days) is medically necessary. There would be certain maintenance of effort requirements with respect to inpatient beds and outpatient funding for psychiatric services on a state electing this option.

J. DISCUSSION DRAFT OF H.R. ____, REQUIRE HHS TO ACT WITHIN A CERTAIN TIMEFRAME IN IMPLEMENTING GAO'S RECOMMENDATION FOR HHS TO EXECUTE A STRATEGY RELATED TO INFANTS WITH NEONATAL ABSTINENCE SYNDROME

²⁸ Government Accountability Office, *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding* (Mar. 2018) (<https://www.gao.gov/assets/700/690581.pdf>).

According to the National Institute for Drug Abuse, there has been a dramatic increase in NAS associated with the opioid epidemic.²⁹ In 2015, every 25 minutes a baby was born suffering from opioid withdrawal.³⁰ The use of opioids during pregnancy can result in NAS, which leads to lengthy and costly hospital stays. In 2012 there were 21,732 babies born with this syndrome – a 5-fold increase from 2000.³¹

The discussion draft effectuates a recommendation by the Government Accountability Office (GAO) published on October 4, 2017, entitled: “Federal Action Needed to Address Neonatal Abstinence Syndrome.” This report was requested by Congress as part of The Comprehensive Addiction and Recovery Act of 2016, which included a provision for GAO to examine Neonatal Abstinence Syndrome (NAS) in the United States and related treatment services covered under Medicaid. Specifically, the discussion draft requires HHS to establish a strategy to implement recommendations that will enhance the treatment and care of newborns suffering from NAS. The strategy must include a timeline for the implementation, how HHS plans to disseminate best practices to state health agencies, and any additional statutory authorities HHS needs to complete this strategy.

K. DISCUSSION DRAFT OF H.R. ____, DEMONSTRATION PROJECT TO EXPAND PROVIDER CAPACITY FOR SUD IN MEDICAID

The discussion draft would create a demonstration project for five years for up to 10 states that have committed to Medicaid delivery system advancements through SUD demonstration waivers. This measure would allow eligible states to receive an enhanced FMAP for provider incentives, training and technical assistance, and other activities to enroll new providers treating substance use disorders in Medicaid or expand existing substance use disorder provider capacity.

L. DISCUSSION DRAFT OF H.R. ____, QUALITY REPORTING FOR SUBSTANCE USE DISORDERS

The discussion draft would require all state Medicaid programs to report the CMS behavioral health core set, which includes measures that will provide a more complete view of SUD treatment in the Medicaid program that will inform Congress, CMS, and stakeholders on how to target improvements for beneficiaries moving forward.

M. H.R. 4998, HEALTH INSURANCE FOR FORMER FOSTER YOUTH ACT

Introduced by Rep. Bass (D-CA), the bill would amend current law to allow foster youth to continue to receive Medicaid benefits even if they move to another state. Under current law,

²⁹ National Institute on Drug Abuse, *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome* (Sept. 2015) (<https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/nasinfoGraphic.pdf>).

³⁰ *Id.*

³¹ *Id.*

foster youth who are enrolled in Medicaid before they turn 18 may stay in Medicaid until the age of 26. However, such foster youth lose their Medicaid coverage if they move out of the state in which they received foster care before the age of 18, for any reason.³² Health insurance coverage is vital to ensuring independence into young adulthood for foster youth. Children in foster care, often because of the harmful environment that lead to their involvement in the system itself, are at high risk for SUD or have often been impacted by SUDs. According to the Georgetown Center for Children and Families, children in foster care use mental health services at a rate 15-20 times higher than the general pediatric population and 25 percent have three or more chronic conditions. The foster care system is especially burdened by the opioid crisis itself, as children from primarily poor and minority families are removed from the homes of parents with OUDs. The extension of Medicaid to foster youth until age 26 creates parity with other parts of the ACA that extended the ability of children to remain on their parent's insurance until they were 26, regardless of their movement between states.³³

N. H.R. 1925, AT-RISK YOUTH MEDICAID PROTECTION ACT OF 2017

Introduced by Rep. Cardenas (D-CA), H.R. 1925 would require a state Medicaid program to suspend, but not terminate, a juvenile's Medicaid coverage when the juvenile is incarcerated. Under this legislation, a state would suspend coverage, but must restore coverage immediately upon release without requiring a new application unless the individual no longer meets the eligibility requirements for medical assistance. According to the Kaiser Family Foundation, suspending eligibility would make it easier to receive services immediately after release and improve access to care and broader benefits, such as reduced recidivism.³⁴

O. DISCUSSION DRAFT OF H.R. 4005, MEDICAID RE-ENTRY ACT

The discussion draft, based on H.R. 4005 introduced by Rep. Tonko (D-NY), would allow state Medicaid programs to receive federal matching dollars for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release. Currently, Medicaid coverage terminates upon entry into incarceration, and there can be delays in re-enrolling or receiving access to care upon release. Individuals recently released from prison

³² First Focus, State Policy Advocacy and Reform Center, *Medicaid to 26 for Former Foster Youth: An Update on the State Option and State Efforts to Ensure Coverage for All Young People Irrespective of Where They Aged Out of Care* (Oct. 2015) (<http://childwelfareparc.org/wp-content/uploads/2014/10/Medicaid-to-26-for-Former-Foster-Youth7.pdf>).

³³ Georgetown University Health Policy Institute, Center for Children and Families, *Implementing the ACA's Extension of Medicaid to Former Foster Youth* (May 31, 2013) (<https://ccf.georgetown.edu/2013/05/31/implementing-the-acas-extension-of-medicaid-to-former-foster-youth/>).

³⁴ Kaiser Commission on Medicaid and the Uninsured, *State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration* (Aug. 2015) (<http://files.kff.org/attachment/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration>).

are up to 129 times more likely to die of a drug overdose than the general population in the same state.³⁵ The transition to services such as MAT would begin before an inmate is reintroduced into society. The unstable and often stressful nature of that transition, especially with limited access to appropriate care, can cause relapse, recidivism, and overdoses.

P. H.R. 3192, CHIP MENTAL HEALTH PARITY ACT

Introduced by Rep. Kennedy (D-MA), H.R. 3192 would require state Children's Health Insurance Program (CHIP) plans to cover treatment for mental illness and substance use disorders. The bill would also require that eligibility for mental health and substance use disorder benefits follow the same rules as group health insurance plans, with respect to discrimination against health status-related factors such as medical conditions and health history. Adding mental health and substance abuse as a required benefit in the CHIP program will ensure the benefit as an entitlement for pregnant women and children.

Q. DISCUSSION DRAFT OF H.R. ____, MOM IMD

The discussion draft would allow women who are pregnant with Medicaid coverage or who are postpartum mothers of newborns with Medicaid coverage to continue to receive Medicaid benefits when in an IMD (up to first 12 months after delivery). Pregnant and postpartum women often need ongoing healthcare services unrelated to treatment that would be received in an IMD. This legislation ensures that the full range of Medicaid benefits continues while such women are in an IMD, better integrating physical and behavioral health.

R. H.R. 3331, TO AMEND TITLE XI OF THE SOCIAL SECURITY ACT TO PROMOTE TESTING OF INCENTIVE PAYMENTS FOR BEHAVIORAL HEALTH PROVIDERS FOR ADOPTION AND USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY

H.R. 3331, introduced by Reps. Jenkins (R-KS) and Matsui (D-CA), would specify that the Center for Medicare and Medicaid Innovation (CMMI) may test models to provide incentive payments to behavioral health providers for adopting electronic health records technology and using that technology to improve the quality and coordination of care.

S. DISCUSSION DRAFT OF H.R. ____, INCENTIVIZING NON-OPIOID DRUGS

The discussion draft would create a temporary pass-through payment for five years to encourage the development of new non-opioid analgesics for post-surgical pain management in the Medicare Outpatient Prospective Payment System (OPPS).

T. DISCUSSION DRAFT OF H.R. ____, CMS ACTION PLAN

³⁵ Ingrid A. Binswanger, et al., *Release from Prison – A High Risk of Death for Former Inmates*, New England Journal of Medicine (Jan. 11, 2007) (<http://www.nejm.org/doi/full/10.1056/NEJMs064115>).

The bill would require CMS to establish, in collaboration with the Department of Health and Human Services' Task Force on Pain Management, an Opioid Addiction Action plan by January 1, 2019. The plan would include possible improvements to Medicare and Medicaid coverage and reimbursement of MAT and other, non-opioid, chronic pain treatments; innovative payment model demonstration projects for MAT and other treatments; data collection for research; provider education; and expanded access for rural and medically underserved communities.

U. DISCUSSION DRAFT OF H.R. ____, INITIAL PAIN ASSESSMENT

The discussion draft would add a pain assessment as part of the Welcome to Medicare initial examination as well as provide referral to a pain management specialist as indicated, and information regarding non-opioid treatment alternatives to manage chronic pain, as appropriate.

V. DISCUSSION DRAFT OF H.R. ____, ACCESS TO TELEHEALTH SERVICES FOR OPIOID USE DISORDERS ACT

Under current law, Medicare beneficiaries in traditional Medicare can only receive services via telehealth in limited circumstances. In most cases, reimbursement for services delivered via telehealth are only available at certain facilities, and in rural Health Professional Shortage Areas (HPSAs). The discussion draft expands access to telehealth services for Medicare beneficiaries with opioid use disorders by giving the Secretary the authority to lift the originating site and rural HPSA requirements for the treatment of opioid use disorders and co-occurring mental health disorders.

W. DISCUSSION DRAFT OF H.R. ____, ADVANCING HIGH QUALITY TREATMENT FOR OPIOID USE DISORDERS IN MEDICARE ACT

The discussion draft would create a demonstration project for an Alternative Payment Model for treating opioid use disorders. This model includes the development of measures to evaluate the quality and outcomes of treatment and reward coordinated care teams that provide high quality, evidence-based medication-assisted treatment in conjunction with appropriate psychosocial services.

X. H.R. ____, ADDING RESOURCES ON NON-OPIOID ALTERNATIVES TO THE MEDICARE HANDBOOK

The discussion draft would direct CMS to compile education resources for beneficiaries regarding opioid use, pain management, and alternative pain management treatments, and include these resources in the "Medicare and You" Handbook.

Y. H.R. ____, POST-SURGICAL INJECTIONS AS AN OPIOID ALTERNATIVE

The discussion draft seeks to incentivize post-surgical injections as a pain treatment alternative to opioids by reversing a reimbursement cut for these treatments in the Ambulatory Surgical Center (ASC) setting.

Z. H.R. 3528, EVERY PRESCRIPTION CONVEYED SECURELY ACT

Introduced by Reps. Clark (D-MA) and Mullin (R-OK), H.R. 3528 requires electronic prescribing for prescription drugs covered under the Medicare Part D program that are scheduled controlled substances. The bill also includes certain exceptions when e-prescribing requirements may be waived in specific circumstances.

AA. DISCUSSION DRAFT OF H.R. ____, MANDATORY LOCK-IN

The discussion draft requires prescription drug plan sponsors under Medicare Part D to establish drug management programs for beneficiaries that may be at risk for opioid abuse. This bill follows a provision in the Comprehensive Addiction Recovery Act of 2016 (CARA) that permitted drug plans to voluntarily create drug management or “lock-in” programs that limited the number of pharmacies where beneficiaries could obtain certain medications, including opioids. The discussion draft would make these currently voluntary programs mandatory.

BB. H.R. 4841, STANDARDIZING ELECTRONIC PRIOR AUTHORIZATION FOR SAFE PRESCRIBING ACT

Introduced by Reps. Schweikert (R-AZ) and Lujan (D-NM), H.R. 4841 would set standards for electronic prior authorization requests under Medicare Part D in order to encourage greater adoption of electronic prior authorizations in the Part D program.

CC. DISCUSSION DRAFT OF H.R. ____, BENEFICIARY EDUCATION

The discussion draft would require prescription drug plans under Medicare Part D to include information on the adverse effects of opioid overutilization and coverage of nonpharmacological therapies, devices, and non-opioid medications used to treat pain.

DD. DISCUSSION DRAFT OF H.R. ____, EVALUATING ABUSE DETERRENT FORMULATIONS IN PART D

The discussion draft would require the Secretary to study and report to Congress on the adequacy of access to abuse-deterrent opioid formulations for individuals enrolled in Medicare Part D.

EE. DISCUSSION DRAFT OF H.R. ____, PRESCRIBER NOTIFICATION

The discussion draft would require the Secretary of HHS to establish a threshold, based on specialty and geographic area, for which a prescriber of covered Part D drugs would be considered an outlier opioid prescriber. The Secretary would then be required to notify

prescribers identified as outliers and provide resources on proper prescribing methods and other information.

FF. DISCUSSION DRAFT OF H.R. ____, PRESCRIBER EDUCATION

The discussion draft would direct CMS to award grants to eligible entities to educate and provide outreach to outlier prescribers of opioids about best practices for prescribing opioids and non-opioid pain management therapies, and to reduce the amount of opioid prescriptions prescribed by outlier prescribers.

GG. DISCUSSION DRAFT OF H.R. ____, MEDICATION THERAPY MANAGEMENT (MTM) EXPANSION

Medication Therapy Management (MTM) is a limited program designed for beneficiaries who take many medications for more than one chronic health condition so that a pharmacist can work to improve therapeutic outcomes. The discussion draft would expand the eligibility for MTM programs under Medicare Part D to beneficiaries at risk for prescription drug abuse.

HH. DISCUSSION DRAFT OF H.R. ____, CMS/PLAN SHARING

The discussion draft would create new program integrity transparency measures for Medicare Parts C and D that will help facilitate communication between Medicare Advantage (MA) organizations, Part D plan sponsors, and CMS relating to substantiated fraud, waste, and abuse investigations through an electronic program integrity portal.

III. WITNESSES

Panel I:

Kimberly Brandt

Principal Deputy Administrator for Operations
Centers for Medicare & Medicaid Services

Panel II:

John M. Kravitz, CHCIO, MHA

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Geisinger Health System

David Guth

CEO and Co-Founder
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