



Academy of
Managed Care
Pharmacy®

May 31, 2016

Re: S. 524 – Comprehensive Addiction and Recovery Act of 2016

Dear House and Senate Conferees:

The Academy of Managed Care Pharmacy (AMCP) appreciates that the Senate and House have each passed S. 524 and it is now under consideration by your Conference Committee. We wanted to take this opportunity to renew our strong support for passage of S. 524. AMCP supports a holistic, comprehensive, and multi-stakeholder approach among health care providers and patients that truly addresses the opioid epidemic.¹ In particular, AMCP would like to reiterate our support for Section 705 in S. 524 – Programs to prevent prescription drug abuse under the Medicare Program and Title XVIII in the House Amendments to S. 524 – National All Schedules Prescription Electronic Reporting Reauthorization Act.

AMCP is a professional association of pharmacists and other practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's 8,000 members develop and provide a diversified range of clinical, educational, medication and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit.

Section 705 in S. 524

AMCP supports drug management programs for the population of at-risk Medicare beneficiaries. Adoption of S. 524 is one opportunity to better manage opioid addiction in Medicare and therefore AMCP strongly supports Section 504 that would allow for the expansion of drug management programs (DMP) to Medicare Part D beneficiaries and allow them to benefit positively from these programs.

A 2012 CMS study found that less than 1% of beneficiaries would be targeted for a DMP. The study examined the use of potentially unsafe doses of prescription opioids for 90 days. Beneficiaries in hospice or those with a diagnosis of cancer were excluded. The study further found that only 0.7% of Medicare Part D beneficiaries received opioids from at least 4 prescribers and 4 or more pharmacies.² Under S. 524, at-risk beneficiaries are still able to receive prescriptions for non-controlled medications at network pharmacies of their choice.

Rates of prescription drug abuse related to emergency department visits and treatment admissions have reached epidemic levels in the United States. According to the Centers for Disease Control and Prevention (CDC), deaths associated with prescription medications have increased more than 300 percent since 1998, while prescribing rates for these drugs quadrupled between 1999 and 2010. Deaths connected to prescription drug misuse now exceed those from heroin and cocaine combined.³ Moreover, the economic costs of prescription drug abuse are substantial. The nonmedical use of controlled substances results totals

\$72 billion in unnecessary costs annually, including lost productivity, costs to criminal justice system, and health care expenditures.⁴

Managed care organizations have well-established techniques for limiting the abuse or diversion of opiates or other controlled substances for patients who have a history or suspicion of inappropriate utilization, diversion, or abuse of these agents. However, one tool commonly used by the private sector and Medicaid markets that the Medicare Part D program does not permit is the use of a DMP by prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PD) to limit patients with a history of abuse to a single prescriber and/or pharmacy (or chain of pharmacies). Members of Congress, the Centers for Medicare and Medicaid Services (CMS), the Drug Enforcement Administration (DEA), and the Department of Health and Human Services (HHS) Office of Inspector General have all acknowledged the need and expressed support for this type of program.

Forty-six states have successfully implemented DMPs through state Medicaid programs with positive results.⁵ An evaluation of state Medicaid DMPs, performed by a CDC expert panel, concluded that these programs have the potential to reduce opioid usage to safer levels and thus save lives and lower health care costs.⁶

- In 2012, the State of North Carolina announced \$5.2 million in savings from its state Medicaid DMP program.⁷
- In 2009, the Oklahoma Medicaid department found that its lock-in program reduced doctor shopping, utilization rates of controlled substances, and emergency room visits with a savings of \$600 per person in costs.⁸
- Florida reported 1,315 individuals had been placed into its Medicaid DMP between October 2002 and March 2005. During this time period, cumulative savings for medical and pharmaceutical expenses topped \$12.5 million.

A recent study evaluating the clinical outcomes of drug management programs for Medicaid patients found that the proportion of stable patients increased from 31% at 6 months to 78% at 36 months.⁹ In addition, a study evaluating the impact of a single-prescriber and single-pharmacy DMP on health care utilizations and costs within a Medicaid Managed Care Organization in Maryland found that enrollment in a drug management program decreased opioid prescriptions and associated costs among health plan members who exhibited signs of opioid overuse.¹⁰ Therefore, AMCP supports the ability for patients identified as at-risk for opioid overutilization to be entered into a DMP to reduce incidence of doctor or pharmacy shopping.

⁵ Roberts AW, Cockrell Skinner A. Assessing the Present State and Potential of Medicaid Controlled Substance Lock-in Programs. *J Manag Care Pharm.* 2014;20(5):439-46.

⁶ CDC; National Center for Injury Prevention and Control. Beneficiary review & restriction programs. Lessons learned from state Medicaid programs (2012), http://www.cdc.gov/homeandrecreationalsafety/pdf/PDO_beneficiary_review_meeting-a.pdf Accessed on August 25, 2015.

⁷ North Carolina Department of Health and Human Services. 2.3 million pills off the streets, \$5.2 million saved by narcotics lock-in. May 14, 2012

⁸ SoonerCare Pharmacy Lock-in Program Promotes Appropriate Use of Medications. September 9, 2009 [press release]. <http://okhca.org/about.aspx?id=10973>. Accessed on August 25, 2015.

⁹ Theresa R. F. Dreyer, Thomas Michalski, and Brent C. Williams. Patient Outcomes in a Medicaid Managed Care Lock-In Program. *Journal of Managed Care & Specialty Pharmacy* 2015 21:11, 1006-1012

¹⁰ Sarah G. Kachur, Alyson B. Schuster, Yanyan Lu, Elizabeth Patton-LeNoach, Hugh Fatodu, Peter J. Fagan, and Chester W. Schmidt. *Impact of a Single-Provider Lock-In Program for Opiates in a Managed Medicaid Population.* Johns Hopkins University School of Medicine, Baltimore MD

As noted above, DMPs have successfully been used by state Medicaid programs and commercial plans for years but are currently prohibited under Medicare Part D. Opioid misuse by elderly patients, the primary population covered by the Medicare Part D program, is a growing concern in the United States and it is unfortunate that DMPs, along with other clinical and psychosocial interventions, may not be used to allow these individuals to receive the help they need. Furthermore, Medicare beneficiaries who are disabled and under 65 are at the greatest risk for overutilization or inappropriate utilization of opioids thereby strengthening the need for DMPs under Medicare Part D. In addition, a recent consensus document released by the Johns Hopkins Bloomberg School of Public Health highlights the benefits of DMPs and recommends expansion of the DMPs to Medicare Part D beneficiaries.¹¹

Given the success and experience using DMPs, S. 524 would allow PDPs and MA- PDs to proactively identify individuals at risk for controlled substance abuse, misuse or improper utilization. Once identified beneficiaries have appeal rights and can submit their preference for a specific DMP prescriber and pharmacy. The use of DMPs may improve continuity of care among at-risk beneficiaries, while ensuring beneficiaries with legitimate medical needs have continued access to effective pain control.

Title XVIII in the House Amendments to S. 524

AMCP has been a supporter of legislation to reauthorize the national All Schedules Prescription Electronic Reporting Act. AMCP especially supports those provisions that encourage interoperability and the use of health information technology (HIT), e-health records, health information exchanges and e-prescribing. All of these tools will have a direct impact on the workflow of prescribers and dispensers ensuring timely access to a patient's prescription drug history

In most cases, prescribers must exit the electronic health record and pharmacists must exit the pharmacy management system to access a portal or other system outside of the workflow to access the Prescription Drug Monitoring Program (PDMP) database. Providing PDMP information through the electronic health record or through the standardized electronic prescribing system that is available to prescribers and pharmacists may potentially increase access to this data. As you know, a primary purpose of PDMPs is to make data available to qualified users to assist them in reducing and preventing the misuse, abuse and diversion of controlled substance prescriptions.

AMCP believes that one way that Congress can incentivize adoption of real time PDMP data sharing that is integrated into standardized pharmacy and prescriber electronic systems by expanding pilot programs. The Standards and Interoperability Framework is one such pilot that has been adopted by Office of the National Coordinator for Health IT's Office of Standards & Interoperability to support national health outcomes, including Certificate Interoperability, Transitions of Care, Meaningful Use and others.

¹¹ Alexander GC, Frattaroli S, Gielen AC, eds. The Prescription Opioid Epidemic: An Evidence-Based Approach. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland: 2015

AMCP appreciates the opportunity to voice our ongoing support for this legislation designed to address the opioid epidemic. AMCP will continue to work on this important issue and offers our support to you in your efforts. If you have any questions regarding AMCP's comments or would like further information, please contact me at 703-683-8416 or scantrell@amcp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Susan Cantrell". The signature is fluid and cursive, with a long horizontal stroke at the end.

Susan A. Cantrell, RPh, CAE
Chief Executive Officer

cc: The Honorable Patty Murray, The Honorable Lamar Alexander, The Honorable Ron Wyden, The Honorable Orrin Hatch, The Honorable Fred Upton, The Honorable Frank Pallone, The Honorable Chuck Grassley, The Honorable Patrick J. Leahy, The Honorable Bob Goodlatte and The Honorable John Conyers