AMCP Academy of Managed Care Pharmacy®

February 22, 2016

The Honorable Orrin G. Hatch
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Senate Finance Committee Hearing – "Examining the Opioid Epidemic: Challenges and Opportunities"

Dear Chairman Hatch and Ranking Member Wyden:

The Academy of Managed Care Pharmacy (AMCP) appreciates the opportunity to submit comments for the record on the hearing titled "Examining the Opioid Epidemic: Challenges and Opportunities" scheduled for February 23, 2016. AMCP supports a holistic, comprehensive, and multi-stakeholder approach among health care providers and patients that truly addresses the opioid epidemic.[1] On the federal level, AMCP supports drug management programs for the population of Medicare at-risk beneficiaries. Adoption of federal legislation on this issue is one opportunity to better manage opioid addiction in Medicare and therefore AMCP strongly supports S.1913 - "*The Stopping Medication Abuse and Protecting Seniors Act*" that would allow for the expansion of drug management programs to Medicare Part D beneficiaries and allow these patients to benefit positively from these programs.

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.

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.[2] 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.[3]

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[1] Proceedings of the AMCP Partnership Forum: Breaking the Link Between Pain Management and Opioid Use Disorder J Manag Care Spec Pharm 2015 Dec;21(12):1116-1122.

[2] Theresa R. F. Dreyer, Thomas Michalski, and Brent C. Williams. Patient Outcomes in a Medicaid Managed Care Lock-In Program. J Manag Care Spec Pharm, 2015 Nov;21(11):1006-1012.

[3] Centers for Disease Control and Prevention. Prescription painkiller overdoses in the US. November 2011. Available at: http://www.cdc.gov/vitalsigns/painkilleroverdoses/ Accessed on August 25, 2015.

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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 drug management plan (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.[4] 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.[5]

- In 2012, the State of North Carolina, announced $5.2 million in savings from their state Medicaid DMP program.[6]
- 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.[7]
- Florida reported 1,315 individuals had been placed into their 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.[8] In addition, a study evaluating the impact of a single-prescriber and single-pharmacy drug management program 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.[9] 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.

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[4] 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.

[5] 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.

[6] 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

[7] 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.

[8] 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

[9] 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.[10]

Given the success and experience using DMPs, AMCP urges you to support S. 1913**.** This legislation 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.

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.[11] Under S. 1913, at- risk beneficiaries are still able to receive non-controlled prescriptions at network pharmacies of their choice.

AMCP appreciates that under your leadership that the Finance Committee is identifying challenges and opportunities on this important issue. AMCP will continue to work on this 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,

Susan A. Cantrell, RPh, CAE
Chief Executive Officer

cc: The Honorable Senator Pat Toomey

[10] 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

[11] Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Centers for Medicare and Medicaid Services, April 2, 2012 Available at http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=15078 Accessed September 4, 2015.