TESTIMONY

Before The

UNITED STATES SENATE FINANCE

HEALTH CARE SUBCOMMITTEE

FIELD HEARING

On

OPIOID/HEROIN ABUSE IN NORTHEASTERN PENNSYLVANIA

On

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Senator Toomey, on behalf of the Academy of Managed Care Pharmacy (AMCP), I would like to thank you for inviting me today to speak on the growing public health problem of opioid and heroin addiction. It is a problem that has reached epidemic proportions. As you know AMCP members have supported your efforts from the beginning on this issue and will continue to advocate for strides to address this problem. I appreciate the opportunity to voice support for your tireless efforts and leadership on an issue affecting one of our most vulnerable populations – beneficiaries and families of those enrolled within the Medicare Program.

My name is Eric Wright. I am a pharmacist, currently directing the Center for Pharmacy Innovation and Outcomes at Geisinger Health System. Geisinger is an integrated health delivery network with a mission to provide the best health care to those we serve. A full overview of Geisinger and AMCP are included at the end of my testimony.

It is certain that opioid abuse is a problem in Pennsylvania and nationwide. According to the Centers for Disease Control and Prevention (CDC), there were 47,055 drug overdose deaths nationwide in 2014, a 6.5% increase from 2013.[1] 61% of these deaths, or 28,809 were attributed to opioids, a 14% increase from 2013. Since 2000, deaths associated with prescription medications have tripled while prescribing rates for opioids quadrupled between 1999 and 2010.[2] Within the past 4 years, deaths from heroin have increased at a steeper rate than prescription opioids (suspected to be due to increased availability of variable potency heroin acquired at lower street prices than prescription opioids)[3], but prescription drugs still account for a larger number of deaths than all other illicit drugs combined. In addition, evidence suggests that doctor and pharmacy shopping is associated with a higher odds of drug-related death.[4] Within Pennsylvania, the concern is even more apparent. According to US Census data, with more than 12 million people, Pennsylvania accounts for about 4% of the US population, yet Pennsylvania contributed 5.8% of overdose deaths in 2014 nationwide. More than 7 Pennsylvanians die each day from drug overdose. In 2014, 2,732 deaths from drug overdoses were reported, a 12.9% increase from 2013, which is larger than the national average of 6.5%.[1] The Pennsylvania Medical Society reports that more Pennsylvanians die from drug overdoses than from any other type of injury, including car accidents.[5] Moreover, the economic costs of prescription drug abuse are substantial. The nonmedical use of controlled substances amounts to $73 billion annually in unnecessary costs, including lost productivity, increased costs to the criminal justice system, and health care expenditures.[6,7,8]

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[1]Rudd RA, Aleshire N, Zibbell JE, Gladden MR. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. MMWR 64(50);1378-82. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm

[2]Paulozzi LJ, Jones C, Mack K, Rudd RA. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. MMWR 2011; 60:1487-92. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w#fig2

[3]Perez E, Dunnan T, Ford D. Ready access, low cost, pill-like high: Heroin's rise and fatal draw. CNN, February 4, 2014. Available at: http://www.cnn.com/2014/02/02/us/heroin-use-rising/ . Accessed March 11, 2016.

[4]Peirce GL, Smith MJ, Abate MA, Halverson J (2012) Doctor and Pharmacy Shopping for Controlled Substances. Medical Care 50:494-500.

[5]Opioid Abuse Resource Center. Pennsylvania Medical Society. Available at: http://www.pamedsoc.org/opioidresources Accessed March 11, 2016.

[6]Centers for Disease Control and Prevention. Prescription painkiller overdoses in the US. November 2011. Available at: http://www.cdc.gov/vitalsigns/painkilleroverdoses/ Accessed March 11, 2016.

[7]Ghate SR, Haroutiunian S, Winslow R, McAdam-Marx C. Cost and comorbidities associated with opioid abuse in managed care and Medicaid beneficiaries in the United States: a comparison of two recently published studies. J Pain Palliat Care Pharmacother. 32010;24(3):251-58.

[8]Hansen RN, Oster G, Edelsberg J, Woody GE, Sullivan SD. Economic costs of nonmedical use of prescription opioids. Clin J Pain. 2011;27(3):194-202.

The statistics are undeniable, but the personal toll is even more concerning. All too often, many of us know someone who is battling drug addiction. There is a definite need for action on many fronts to address this growing concern. Patients, pharmacists, doctors and other health care providers, patient family members, health plans, community based organizations, employers, and the government **must all work together** to formulate and implement solutions.

Geisinger's ongoing efforts to address the opioid epidemic. At Geisinger, we are committing to making a difference in the problem and have implemented a multifaceted approach involving not only Geisinger employees, but the community at large. Through our pain management program, we have worked to address pain appropriately and systemically lower opioid prescribing. We house acute and chronic rehabilitation facilities and have increased the outpatient care for recovering addicts through support of outpatient clinics in Wilkes-Barre and Scranton. With many partners within the Commonwealth (including law enforcement, environmental groups, Universities and pharmacies), Geisinger is leading initiatives aimed at removing drugs from homes with our expanded medication take-back initiatives working to responsibly dispose of unused, unwanted or expired medications within the community and keep drugs of abuse from landing in the wrong hands. Being an integrated delivery system with a health insurance arm, we have the capacity to see the types of medications our patients are prescribed, how much and where our patients are filling drugs of abuse. This information allows us to look across our patient population for anomalies (as suggested by the Commonwealth) for potential doctor shopping and abuse. Those suspected of opioid abuse problems in our Medicaid plans can be enrolled into restriction programs (a/k/a. Lock-in programs). We currently have 27 patients enrolled in a drug management program (DMP), limiting medication fills for opioid products to one pharmacy and one provider. We have had very good success with this program and is one mechanism used to address medication abuse. Unfortunately, this tool of identifying the at-risk population is not available to our Medicare population. The Medicare Part D Program does not currently permit 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, misuse or diversion to a single prescriber and/or pharmacy.

Last week, I was pleased to learn that the Senate voted to amend S. 524 - the Comprehensive Addiction and Recovery Act of 2016 (CARA) with the language of Senator Toomey's Bill S. 1913, "Stopping Medication Abuse and Protecting Seniors Act of 2015". CARA now includes provisions that will allow PDPs and MA-PDs to proactively identify individuals at risk for controlled substance abuse, misuse or improper utilization. The Secretary of Health and Human Services (HHS) would determine the criteria for the "at risk" designation. The plans would work with a beneficiary's prescriber and give the beneficiary notice that they had been identified as a potential participant for enrollment in a DMP. The beneficiary has appeal rights and can submit their preference of a specific prescriber and pharmacy. The use of DMPs may improve continuity of care among at-risk plan beneficiaries, while ensuring beneficiaries with legitimate medical needs have continued access to effective pain control. Furthermore, at risk beneficiaries are still able to receive non-controlled prescriptions at other pharmacies and from other prescribers. Another advantage of a DMP is that it works as prospective identification program allowing the plan to act in real time; as opposed to a retrospective program which combs through past data to find anomalies.

DMPs have been around for some time and reduce doctor and pharmacy shopping while improving health. DMPs have been successfully utilized by state Medicaid programs for over a decade. On the state level, forty-six state Medicaid programs have successfully implemented DMPs with positive

results.[9] 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 lower health care costs.[10] 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 over $600 per person over 12 months.[11] A study from North Carolina in 2012 announced $5.2 million in savings from their state Medicaid DMP program.[12] Finally, Florida reported 1,315 individuals had been placed into their Medicaid patient review and restriction program between October 2002 and March 2005. During this time period, cumulative savings for medical and pharmaceutical expenses topped $12.5 million.[13] Similar benefits are expected within the Medicare population, as earlier this year, legislative language contained in another bill creating a DMP in Medicare Part D for at-risk beneficiaries received a score from the Congressional Budget Office saving $115 million over 9 years.

In terms of the impact to beneficiaries, a 2012 CMS study found that less than 1% of beneficiaries would be directed into a DMP. 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, signaling a high-risk patient.[14] Those beneficiaries in hospice or those with a diagnosis of cancer were excluded from the study. The limited number of beneficiaries that may be included in the DMP is encouraging because it is an indicator that the majority of beneficiaries will not have any change in their prescriber or pharmacy. On the other hand, that small group of beneficiaries that are at-risk, will have an opportunity to receive better coordination of care by the prescriber, pharmacy and PDP working together through the DMP.

The language in S. 1913 now included as part of S. 524 strikes the appropriate balance of prospectively identifying at-risk beneficiaries and help them obtain the necessary treatment sooner to address addictions potential abuse while simultaneously preserving a beneficiaries' rights to be notified, submit their preferences for prescriber and pharmacy, and exercise appeals.

On behalf of myself and AMCP, we strongly support S. 524 and your tireless efforts to address this important societal problem. Thank you again for inviting me to speak here today and deliver this testimony.

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[9] 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.

[10] CDC; National Center for Injury Prevention and Control. Patient review & restriction programs. Lessons learned from state Medicaid programs (2012), http://www.cdc.gov/drugoverdose/pdf/pdo_patient_review_meeting-a.pdf Accessed March 11, 2016.

[11] Katz NP, Birnbaum H, Brennan MJ et al. Prescription Opioid Abuse: Challenges and Opportunities for Payers. Am J Manag Care. 2013;19(4):295–302.

[12] Werth SR, Sachdeva N, Roberts AW, et al. North Carolina Recipient Management Lock-In Program: The Pharmacist's Perspective. J Manag Care Spec Pharm. 2014;20:1122-8.

[13] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. Patient review & restriction programs. Lessons learned from state Medicaid programs. August 27-28, 2012. Available at: http://www.cdc.gov/drugoverdose/pdf/pdo_patient_review_meeting-a.pdf. Accessed March 11, 2016.

[14] 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 March 11, 2016.

AMCP is a national professional association of 8,000 pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to assist patients in achieving positive therapeutic outcomes. In Pennsylvania alone, we have over 480 active members. AMCP's members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit.

Geisinger Health System is an integrated health services organization widely recognized for its innovative use of the electronic health record and the development of innovative care delivery models such as ProvenHealth Navigator® and ProvenCare®. As one of the nation's largest health service organizations, Geisinger serves more than 3 million residents throughout 45 counties in central, south-central and northeast Pennsylvania, and also in southern New Jersey with the addition of AtlantiCare, a National Malcolm Baldrige Award recipient. The physician-led system is comprised of approximately 30,000 employees, including nearly 1,600 employed physicians, 12 hospital campuses, two research centers and a 510,000-member health plan, all of which leverage an estimated $8.9 billion positive impact on the Pennsylvania economy. Geisinger has repeatedly garnered national accolades for integration, quality and service. In addition to fulfilling its patient care mission, Geisinger has a long-standing commitment to medical education, research and community service.