Kentucky Responses

1. **How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?**

Joyce Johnson, MSN, APRN, AGNP-C
Intensive Health

CMS payment incentives - Research has shown recently that there is minimal to no place in most chronic pain for opiates and sufficient evidence for potential and likely harm. This is born out by the recent CDC guidelines published in 2015. Reimbursement rates could be increased by a percentage to prescribers who are incorporating these guidelines into practice. This could be monitored in a number of ways, however most of them would likely increase bureaucracy and therefore regulatory burden. In 2012 in Kentucky, we passed HB1 which regulated the prescribing of controlled substances in our state, among other things. The impact evaluation on HB1 done in 2015 found that nurse practitioners as a group prescribed less than 10% of all controlled substances found on the PDMP, KASPER. In addition, many high-prescribers who did not meet the requirements of this legislation stopped prescribing and many "pill mill" and pain clinics closed. This impact report also found that treatment center (rehab) admissions, hospitalizations, and hospital discharge for prescription opiate addiction and overdose decreased after the passage of HB1, while treatment center admissions, hospitalizations, and hospital discharges for heroin addiction and overdose increased. This could be interpreted that when people lost access to prescription opiates, they turned to heroin which is, obviously, an unintended consequence. This is partly due to patients who were no longer able to receive their prescribed opiates then turned to illicit opiate sources; the issue of supply and demand can be identified as well - when supply of prescription opiates decreased, the price went up while heroin remained relatively cheap and more people started using heroin. The addition of illicit fentanyl to heroin in our state allowed more overdoses to occur and significantly increased helathcare costs to manage these overdoses. This trend has continued since 2015 and while it is not solely attributable to the HB1 legislation, it's reasonable to place some of this on HB1. The impact report I reference can be found here: http://www.chfs.ky.gov/NR/rdonlyres/842D66B1-612C-4A26-9FE2-C526329D0BEE/0/KentuckyHB1ImpactStudyExecutiveSummary03262015.pdf
I think that any regulation that restricts the ability of prescribers to prescribe opiates must be coupled with emphasis on evidenced based treatment (slow tapers vs simply cutting off prescriptions, incentivizing nonscheduled, nonhabit forming therapies, etc) or we will find more unintended consequences. Payment incentives like increased reimbursement can be applied to this principle by following guidelines already in place from the CDC, ASAM, SAMHSA, and other appropriate agencies. In addition, with Medicare's shift from volume-based reimbursement to value-based reimbursement, the consideration of patient satisfaction scores like HCAHPS and Press-Ganey scores in determining reimbursement should be eliminated. While patient satisfaction with care is important, it does not provide any meaningful reflection on outcomes. Linking patient satisfaction scores to provider reimbursement promotes irresponsible and

inappropriate prescribing by attempting to keep patients happy and satisfied, incentivizing prescribers to treat patients how the patient would like to be treated which is not necessarily what is appropriate, and prolongs the "pain as the 5th vital sign" mentality that helped lead to an increase in opiate prescribing to start with. If these surveys must be kept, pain management should be eliminated as a factor in determining this assessment. These surveys could also be collected but play no role in reimbursement rates. This 2% in reimbursement could come, instead, from outcomes data or evidence of functional improvement.

Michael Rust
President, Kentucky Hospital Association

There remains little evidence that chronic pain is best treated with opioids. For patients with new chronic pain conditions not currently receiving chronic opioid analgesic therapy (COAT), Medicare and Medicaid may consider instituting prior authorization requirements before initiation of any new opioid prescription lasting longer than 14 days. This could be modeled after the prior authorization form for COAT from Amerigroup (see attachment); specifically sections A, B, C, and D are applicable. For patients continuing COAT, annual approval should be contingent on meeting appropriate safety measures, ensuring benefit outweighs risk, and providing psychosocial therapy as part of a comprehensive treatment plan. Modeling after Delaware Medicaid and Medical Assistance Program, place restrictions on the ability of individuals to obtain concomitant prescriptions for opioids and benzodiazepines, such that this dangerous combination is less readily available without clear risk:benefit analysis. Modeling after Oregon Medicaid, place formulary restrictions on opioids requiring other analgesics and nonpharmacologic strategies be used first (or at least concomitantly), limiting the days' supply per prescription, and requiring documented improvement in function for continued use. As part of the Comprehensive Addiction and Recovery Act of 2016, the Secretary of Health and Human Services (HHS) established the Pain Management Best Practices Inter-Agency Task Force to, along with other responsibilities, review best practices in pain management and report gaps and inconsistencies to HHS. The Task Force has yet to provide recommendations; therefore the Senate is urged to ask HHS to rapidly move forward with this investigation, as this may provide valuable input to Medicare and Medicaid

Jacob Bast
Senior VP/COO, St. Elizabeth Healthcare

The issue of effective pain management is very real to St. Elizabeth; it is the number one diagnosis within our emergency departments. Identification, adoption, and implementation of evidence-based algorithms related to non-pharmaceutical management of pain would guide optimum care in healthcare facilities. Accompanied by required documentation of the outcomes for implementing non-pharmaceutical therapies could inform the release of financial incentives for facilities/physicians that follow the guidelines/rules. CMS can also retract the reduction in 340b incentives. Getting those extra savings for Medicare beneficiaries helps us to be able to

fund programs like the suboxone clinic, the inpatient coverage loss St. Elizabeth Physicians (SEP) incurs (and will continue to incur for the coverage at SUN Behavioral Health Hospital).

While incentives to providers might help compliance with guidelines, the biggest caveat impeding non-pharmaceutical management is that most therapies are not reimbursable. This is a foundational barrier because patients are less likely to choose that path if their insurance does not cover it. Additionally, the equity of payment between commercial payers and Medicaid continues to be issue. This is very evident in Northern Kentucky where there are specialists that do not accept Medicaid which burdens our organization and limits access/choice for the community.

2. **What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those nonpharmaceutical therapies when clinically appropriate?**

Joyce Johnson, MSN, APRN, AGNP-C
Intensive Health

There are significant barriers to non-pharmaceutical (and non-scheduled) therapies for chronic pain. Lack of access to providers offering these services, lack of coverage, and low reimbursement rates or delayed reimbursement are just a few of the barriers in place. In addition, the lack of focus on complimentary and alternative treatments in chronic pain diminish the usefulness of these therapies. There is some evidence to indicate massage therapy, therapeutic methods like EMDR and CBT, physical therapy, TENS units, chiropracty, accupuncture, hypnosis, etc, are useful in the treatment of chronic pain but often these therapies are limited or not covered at all. More access and better, more timely reimbursements for mental health care is necessary to begin to chip away at this problem. Chronic emotional and mental distress and poor mental health care is frequently manifested psychosomatically into a sensation of chronic pain. There is also a link between addiction and mental health impairment. These factors are often inextricably linked. Oftentimes, we are treating the mental distress as much as the physical distress when dealing with chronic pain. It is challenging to impossible to identify people who are at risk for addiction prior to an addiction developing.

Michael Rust
President, Kentucky Hospital Association

There is a paucity of resources devoted to mental health treatment in the United States, and—given the link between depression and other mental illnesses and chronic pain — this likely contributes to overreliance on opioid analgesics for chronic pain. Over 50% of adults with a mental illness received no treatment in 2014, and one in five Americans in 2016 reported they could not access needed mental health services, most commonly because it was cost prohibitive or not covered by insurance. HHS has previously described the existing and pending shortages of mental health providers; this is compounded by lack of reimbursement to providers for mental health services. Increasing accessibility of mental health services (in rural and urban areas) as well as increasing coverage and reimbursement for mental healthcare, is of utmost importance. Medicare and Medicaid coverage of nonpharmacologic treatment modalities is also lacking. Furthermore, there is substantial evidence supporting the benefit of integrative therapies such as yoga, mindfulness, and cognitive behavioral therapy (CBT) in the treatment of chronic pain; and nonpharmacologic therapies have been recommended for pain management by the CDC, the VA/DoD, and the American Pain Society. Key barriers include cost of treatment and geographical limitations for many patients; providing consistent reimbursement for nonpharmacologic treatment options, including telehealth CBT strategies, is therefore necessary. A requirement for existing nonpharmacologic analgesic therapy at the initiation of COAT (as

discussed previously in response to question #1) would increase awareness and buy-in among providers. Another barrier to utilization of nonpharmacologic therapies is patient and provider awareness. Increasing provider awareness through required training may increase use of comprehensive pain treatment strategies. Vermont allows education regarding alternative pain management strategies to count towards continuing education credit, which is advised. As addressed by the President's Commission on Combating Drug Addiction and the Opioid Crisis (the Commission), reimbursement for "surgical supplies" is provided as an all-inclusive bundled payment that subsequently discourages the use of potentially more expensive multimodal pain treatment strategies. The Committee is urged to recommend CMS review and modify rate-setting bundled payment strategies that discourage nonpharmacologic pain treatment.

Sherri Craig
Division VP, Public Policy, KentuckyOne Health

One barrier we face is denial at pre-certification for inpatient/detox care if opioids are the only substance a patient is abusing. For approval, there has to be a co-occurring mental health concern or abuse of multiple substances.

Jacob Bast
Senior VP/COO, St. Elizabeth Healthcare

As previously indicated, lack of insurance coverage and willing providers (whether private or public pay) for non-pharmaceutical therapies for pain management is the main reason patients are less likely to choose that path if their insurance does not cover it. The quick resolution to pain through pharmaceutical methods is also very attractive to patients. Therefore, the algorithm for non-pharmaceutical management should include patient education and support as well as, in some cases, the use of non-narcotic pharmaceutical products.

3. **How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?**

Joyce Johnson, MSN, APRN, AGNP-C
Intensive Health

This is a fine line to walk. By pouring a large amount of money into SUD identification and treatment, you will have some successes. I believe we could also see an increase in poorly managed facilities and uneducated prescribers that don't provide an added benefit in positive outcomes or long-term recovery for patients. This can be done in a delicate way by closely monitoring the accreditation of new facilities opening up and certification of new providers for adherence to evidenced-based guidelines and patient outcomes. As an example, my company owns 4 treatment centers called Stepworks. With each new facility that opened up, we found that new halfway houses also opened up in the region. Some of these halfway houses were well-run but there were several that we poorly managed, did not provide benefit to our patients, did not improve outcomes, occasionally increased illicit substance access and use, and while they didn't last long, patients were left without resources or assistance when they closed, often unexpectedly. Many patients faced with a closure of their living arrangement relapse. I think careful attention paid to existing and new stakeholders in addiction treatment is the best way to ensure beneficial outcomes and long-term recovery. We can also provide reimbursement for counseling specifically regarding the potential risks and harms of chronic opiates and the benefits and options available to treat pain in other ways. There is currently little time and opportunity to have these meaningful, time-consuming conversations with most patients in an evaluation and management category office visit. Another way to do this would be to provide the assessment and treatment for Medicare (and Medicaid if/where applicable) patients by eliminating coinsurance and deductible requirements, placing this in the category of "preventative care." This would improve patient compliance as well by eliminating the out of pocket financial burden for this assessment and treatment.

Michael Rust
President, Kentucky Hospital Association

Allow clear and easier billing for chronic pain management (as a solitary diagnosis) in line with established guidelines, similar to CPT code 99490. The lack of consistent funding for prevention, identification, and treatment of OUD and SUDs has remained a major barrier to effective management. Therefore the Congress should evaluate consistent funding for OUD and SUD treatment, similar to the model for chronic kidney disease. Consider imposing limits on the number of patients on COAT that a single provider can manage, and allow this number to increase only if the provider has an established track record of safe opioid prescribing (similar to buprenorphine prescribing for OUD restrictions). Similar to psychiatrist prescribing of buprenorphine, specific subspecialties (e.g., oncology) could be exempt. Require all prescribers of controlled substances be certified to prescribe buprenorphine—either via waiver or

subspecialty training—prior to obtaining a DEA license. The Commission has also recommended that CMS remove pain survey questions entirely from patient satisfaction surveys based on multiple studies correlating opioid prescription with patient satisfaction, and therefore creating undue pressure on providers to prescribe opioids, and we support that recommendation.

Lauren McGrath
VP of National Policy, Centerstone America

There is little doubt that what practitioners do, and how they do it, is directly influenced by reimbursement structures and the presence or absence of payment incentives. Therefore, wider use of evidence-based services can be motivated by new payment incentives. Below, we identify changes in payment culture that will lead to improved patient outcomes, while utilizing the healthcare workforce more efficiently and effectively. Incentivize value-based, integrated addiction treatment models . At Centerstone, we are in the process of developing a "Per Member Per Month" (PMPM) model for outpatient treatment housed within in our recovery oriented medication assisted treatment (RO-MAT) framework. This model includes treating the patient holistically, building their recovery capital, and for the majority of our patients, where appropriate, working toward a discontinuation protocol from medication assisted treatment. In all of our models, we include treat-to-target metrics to assess a patient's progress along the treatment continuum. Provide for meaningful reimbursement of mobile crisis services. Due to the opioid epidemic, requests from hospitals for our mobile crisis services, particularly after an individual has overdosed, have increased considerably. Staff time in transit to and from an emergency department, mileage, etc., are not typically adjusted for in our rates, so we provide these crisis services at a financial loss to our system (unless grant funded). While larger entities like Centerstone may be able to absorb this cost temporarily, smaller providers will be unable to do so. Thus, to enable providers of all sizes to continue offering these important and life-saving services, mobile crisis services must be reimbursable in a meaningful way. In evaluating financial models that would incent the appropriate use of mobile crisis services in engaging acute patients, we suggest either a bundled payment model, or an enhanced rate/code specific to mobile engagement. Remove barriers to effective uses of telehealth. According to the National Rural Health Association, 30 million Americans currently live in rural counties where access to addiction treatment services and medications are unavailable. Last week, the Bipartisan Budget Act took steps to facilitate telehealth in Medicare Advantage plans, provide nationwide access to telestroke, and improve access to telehealth-enabled home dialysis therapy. This is a great step towards removing barriers to the use of telehealth, but the same can be done for telebehavioral health. Effective and well-vetted prevention and treatment strategies exist for opioid misuse and addiction today, but are highly underutilized across the United States. Fully optimizing the value of our behavioral health workforce by affording them a wider latitude to treat patients with substance use disorders (SUDs) via telemedicine is a prudent and timely policy step. Ensure that reimbursement protocols reward, instead of burden, trusted providers. With medication-assisted treatment now widely accepted as a way to help OUD and SUD patients, there is an increasing potential for rogue actors to enter this space. Lawmakers should take steps to make sure that federal dollars are not misused by inadvertently flowing to "MAT pill mills," which offer

suboptimal care to patients and may even exacerbate the problem dedicated providers are aiming to fix. In several of our accredited addiction treatment facilities in multiple states, our medical staff report experiencing record levels of insurance denials for OUD treatment and, in some cases, report being asked to submit upwards of 70 pages of clinical documentation to treat one patient. This disconnect between quality and reimbursement has fostered an environment in which predatory MAT prescribers thrive and quality providers, connected to a full continuum of care rooted in nationally recognized clinical models, are financially hindered by record levels of burdensome authorizations and denials. Please ensure that trusted providers get timely reimbursed for the medically appropriate services they provide so that patients can get real treatment. Specifically: Tie federal dollars to evidence-based services only. To ensure quality in patient care and outcomes, we recommend that providers serving Medicaid/Medicare eligible beneficiaries for SUD demonstrate the ability to offer a comprehensive continuum of evidence-based services. Payment models should be linked to standardized outcomes and designed to incentivize integrated, whole-person care models for addictions treatment, particularly for patients with co-occurring and complex conditions. Develop a "gold standard" certification that would establish "clinical excellence hubs" as preferred providers for courts, corrections, emergency departments, etc. for trusted patient referrals. These excellence centers would need to demonstrate use of evidence-based interventions, linkages to a full continuum of care, including services geared towards increasing patients' recovery capital, and report on patient outcomes. Excellence centers could be eligible for federal funds for successful completion of treat-to-target metrics, such as:

- *Superb Customer Service*
  - This would be measured by the Health Home customer service survey, which asks:
  - "How likely is it that you would recommend (provider's name) health home to a friend or colleague?"
  - "How confident do you feel managing your condition(s)?"
  - "How connected do you feel to your care team?"

- *Excellent Access to Care*, as measured by:
  - % clients receiving appropriate level of care engagement intensity
  - % clients who access routine care < 10 days
  - % clients who access urgent care < 3 days

- *Treat-to-Target Care Process goals*, as measured by:
  - % of clients whose improvement is tracked
  - % of clients not improving that:
    - receive a significant treatment plan change;
    - are staffed in a treatment team meeting

        - % of clients that experience symptom improvement to ASAM Level I.
        - % of urine analyses which come back free of drugs of abuse. (Note: this outcome measure can assist in drawing a line between MAT pill mills and providers who are appropriately administering MAT.)

    - *Treat to Target Care Outcome Goals*, as measured by:
        - Increase Recovery Capital (measured via the Centerstone Recovery Capital assessment)
        - Decreased hospital & ER days
        - Decreased functional impairment
        - Decreased substance use

Jacob Bast
Senior VP/COO, St. Elizabeth Healthcare

There are multiple barriers to accessing care:

- Primary barriers for persons with OUD and other SUDs are transportation, child care, housing, and work;
    - providing transportation vouchers helps, but patients cannot get a voucher if there is more than 1 car in the household where they live – and if someone else in the household needs the car for work, treatment suffers. This should not be a stipulation around getting a transportation voucher;
    - child care vouchers are available for some patients but hours of treatment often don't coincide with day care if a person is working
    - to be eligible for Medicaid, patients must verify stable housing – this is often a problem because persons with addiction often move from house to house or the street
    - work – currently in Kentucky, the newly approved Medicaid waiver includes work or community engagement requirements of at least 20 hours a week for able-bodied adults to be eligible for Medicaid coverage. This requirement may interfere with treatment so the hope is that some of the out-patient treatment hours could count toward the required number of work hours.
- Other barriers revolve around payment issues:
    - Many providers, such as specialists, do not accept Medicaid and Medicare due to the low reimbursement rate, limiting access to quality, specialized care
    - Insurance stops paying. "Even when insurance covers addiction treatment, it might not cover it at the right level or for the right amount of time. This means that someone living with addiction could be discharged

from treatment because insurance stops paying for treatment, even though the person is continuing to have symptoms, or can't manage living with addiction on his or her own." [Source: National Center on Addiction and Substance Abuse, retrieved from: https://www.centeronaddiction.org/the-buzz-blog/4-common-barriers-addiction-treatment]

- Many services (for example a urine screen) require prior authorization which sometimes takes time, delays treatment, and puts a strain on office staff and delay in treatment. In the example, urine screens should be frequent for persons with SUD. Having to get prior authorization every time is counter-productive.

4. **Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?**

Joyce Johnson, MSN, APRN, AGNP-C
Intensive Health

Medicare/Medicaid prescription drug rules could include quantity limits, step therapy requirements, identification of medical necessity, and prior authorizations for the use of opioids in both acute and chronic pain and removing these barriers for nonscheduled treatment. Prior authorizations and other drug plan rules occur frequently in more expensive, nonscheduled pain management therapies and are less frequent in opiates that typically are cheaper. Tying these PAs and other drug rule requirements to duration of therapy, morphine equivalents per day less than 90, no concurrent use with benzodiazepines unless with identified medical necessity in concurrence with existing guidelines could provide some benefit however the argument exists that there is potential for increase in illicit use as an unintended consequence. As my collaborating physician, who is board-certified in addiction medicine, once said, "There's no place for a 'big-stick' approach for these patients." At the end of the day, individualized treatment must be the focus moving forward.

Michael Rust
President, Kentucky Hospital Association

In addition to previous recommendations, require all healthcare providers, especially prescribers, complete REMS educational modules around opioid use, pain treatment, and OUD

Jacob Bast
Senior VP/COO, St. Elizabeth Healthcare

Last year, St. Elizabeth Physicians/primary care offices incurred 1.4 million visits that required Prescription Drug Monitoring Program (PDMP) reports. Enabling the timely download of these reports (known in KY as Kentucky All Schedule Prescription Electronic Reporting, or KASPER) by authorized staff better prepares the prescribing clinician to make prescribing decisions. If the reports are not accessed in a timely way, it limits the effectiveness of the system. Currently, not all states mandate that clinicians check a system prior to writing a prescription facilitates. If all states were mandated to have a system, there would be better monitoring of controlled substances.

5. **How can Medicare or Medicaid better prevent, identify, and educate professionals who have high prescribing patterns of opioids?**

Joyce Johnson, MSN, APRN, AGNP-C
Intensive Health

Improving access to addiction education currently provided by SAMHSA could aid high-opioid prescribers in more responsible prescribing. This could be linked to certification requirements for continuing education for all providers with a DEA license. Eliminating aggressive marketing of controlled substances to providers by all pharmaceutical companies could also positively impact prescriber behavior. Currently, PDMPs are state-based. I feel that this should be a national repository much like the finger-printing system used in law enforcement. Recently, I had a patient I'm caring for in Kentucky who had a PDMP (KASPER) report that was blank, meaning he had received no controlled substances in Kentucky. He was going out of state and receiving controlled substances in another state whose PDMP I did not have access to and therefore was unaware of this behavior. My patient did not disclose this to me. He ended up overdosing. With each state having a separate PDMP, it is unreasonable and almost impossible to monitor my patient's behavior and treatment by other providers especially with travel being so frequent and accessible. Patients often have homes in other states, visit family in other parts of the country, or travel to other places for work and leisure. They will also travel across state lines to fill prescriptions in a way that is less easy to track. Providers with high rates of prescribing could also be monitored more easily with a national system. All prescriptions are linked to a federal DEA number so the access to this information can be found in one system vs 51 systems.

Michael Rust
President, Kentucky Hospital Association

In addition to previous recommendations, a national prescription drug monitoring program (PDMP), modeled after the highest-functioning state PDMP(s), is necessary, as is appropriately comparing prescribers to their peers. This is not to infringe on the rights of the States, but to better standardize data collection and access for identification and education as well as to improve the validity of comparison by increasing the denominator of peers. Identifying specific metrics as targets for educational intervention (e.g., percent of patients over 90 MME, co-prescribed opioids with benzodiazepines, etc.)1 will help delivery of targeted education to high-risk prescribers, such as those in a top percentile.

Jacob Bast
Senior VP/COO, St. Elizabeth Healthcare

Physicians and other prescribing clinicians who fall outside the prescribing norm are reported to the licensing boards. When that happens, they run the risk of losing their licensure. Required mandates for continuing education increase the likelihood of best practices. Meeting the current three-year mandates for prescribing education seems sufficient.

6. **What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?**

Michael Rust
President, Kentucky Hospital Association

Washington's PDMP began sharing data with Medicaid in 2011, and the benefits to the PDMP and to Medicaid are numerous. With strict provisions over how data should be handled and what steps may be taken by Medicaid/Medicare with PDMP data (so as to not open the door to inappropriate claims denial), mandatory data sharing would allow for earlier identification of high risk patients—and therefore access to treatment—as well as targeted education as previously discussed.

Lauren McGrath
VP of National Policy, Centerstone America

Create a national standard for an interoperable, real time PDMP. Technology and standards that are available today across the country, in doctors' offices and at pharmacy counters, have the ability to inform, standardize and enhance the information that is available to clinicians at the points of prescribing and dispensing. Prescription drug monitoring programs (PDMPs) are crucial sources of data for providers and pharmacists alike; however, PDMPs could have a larger impact in combatting the opioid epidemic if challenges in the current system were addressed. Current challenges include: interoperability among states and with other health IT, real-time data and information that is in the workflow and user-friendly for providers. Interoperability: PDMPs are profoundly different across states and in how they are integrated with health IT in each state. These differences present many challenges, and limit data access to providers at point of care. Improving interoperability of PDMPs will allow providers the ability to check patient prescription histories, alert providers to individuals with patterns indicative of misuse, and prevent patient doctor shopping. Real-time: PDMPs currently run on batched information, only being utilized retroactively to track dispensing data for patients. If improvements to the current system are made, prescriptions could be stopped before they are dispensed, or even before the prescription is written. It is at this point that a clinician would have the opportunity to not only stop the medication from potentially falling into the hands of an individual exhibiting addictive behaviors, but to address those potential harmful behaviors and help refer to treatment or alternate therapies. Policies be put in place to mandate real-time reporting, which would allow for providers to make clinical decisions at point-of-care, and make the health care process more uniform, accurate, collaborative, and patient-centered. Within workflow: In order to check a state's PDMP, most clinicians are required to log in to a system separate from their normal medical record software (EHR, prescription dispensing system, etc.), query the site, analyze the report results, and then return to their original workflow. In order for PDMPs to have a greater impact, they should be made accessible in existing provider software. These improvements will ensure PDMP data is utilized at point-of-care and that this data can be shared in real-time across the network. Utilize PDMP's to link patients to treatment by automating, or incenting, an SBIRT

function: Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based preventative measure designed to move patients, who may need help, into treatment. SBIRT uses tools like Motivational Interviewing to identify those at risk for developing an SUD and help those who already have an SUD. Generally, SBIRT increases an individual's chance for early intervention and access to treatment. Align 42 CFR Part 2 with HIPAA. Currently, only federally assisted alcohol and drug abuse programs providing SUD diagnosis or treatment are subject to the stringent Confidentiality of Substance Use Disorder Patient Records rule – 42 CFR Part 2. Part 2 prevents these federally funded providers from accessing a patient's full substance use history without the patient's prior written consent. In contrast, private practitioners or providers within for-profit programs providing SUD diagnosis and/or treatment are not automatically subject to this regulation, and may treat SUD-related patient records like any other medical record under HIPAA. A private practitioner who does not use a controlled substance for treatment, such as Naltrexone, for example, is not subject to Part 2. It is crucial for front-line providers to have full access to patient records in order to provide safe patient care. Common sense legislation like The Protecting Jessica Grubb's Legacy Act, S. 1850, co-sponsored by Senators Shelley Moore Capito (R-WV) and Joe Manchin (D-WV), would align Part 2 with HIPAA for the purposes of treatment, payment, and health care operations, and strengthen protections against the use of substance use disorder records in criminal proceedings. Doing so would increase care coordination and integration among treating providers and other entities in communities across the nation.

Jacob Bast
Senior VP/COO, St. Elizabeth Healthcare

Requiring all states to have an electronic Prescription Drug Monitoring System that can be linked across state borders will increase the efficacy of this drug control strategy. Data sharing should also be considered as sharing of best practices.

7. **<u>What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?</u>**

Michael Rust
President, Kentucky Hospital Association

Multiple studies have shown the benefit of covering methadone maintenance therapy for OUD. However, Medicaid currently does not cover methadone maintenance therapy in many states. Increasing access to all evidence-based forms of medication assisted therapy, including methadone, is recommended. As previously addressed by Senators McCaskill, Murkowski, and Sullivan, the Ryan Haight Online Pharmacy Consumer Protection Act effectively prohibits the ability of physicians to use telemedicine to provide evidence-based treatment for SUDs. This Act should be amended to allow use of telemedicine to increase access to evidence-based SUD treatment.

Lauren McGrath
VP of National Policy, Centerstone America

Incentivize breakthrough payment models and technology enabled care. Today, providers seeking to provide clinical excellence to their patients, particularly those with complex conditions, are hindered by immense administrative burden due to increasing denials and authorization requirements, lack of meaningful outcomes measures for behavioral health, and electronic health systems that are not fully interoperable. However, we have also seen immense progress when providing integrated treatment through our health home model or are able to engage a high risk consumer through technology enabled care or a recovery coach as a result of a grant or value-based agreement. As clinical models are ready to be deployed, we need the federal government to break down barriers preventing the reimbursement of value-based, innovative care delivery.

Jacob Bast, Senior VP/COO
St. Elizabeth Healthcare

In Kentucky, able-bodied recipients of Medicaid are now required to work at least 20 hours a week. It would be helpful to persons with OUD or SUD on Medicaid or Medicare to have the 9 hours of intensive outpatient be considered part of the 20-hour requirement.

8. **What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?**

Joyce Johnson, MSN, APRN, AGNP-C
Intensive Health

Human services efforts often lag and local funding for them is often minimal. Taking steps to increase community awareness of opioid use disorder as a chronic disease, MAT treatment as a reasonable and appropriate treatment of this condition, and improving patient's access to care would help to address the opioid epidemic. People with addiction often struggle to find employment, maintain economic stability, and improve their station in life. With community outreach, we can educate potential employers on SUD and community members and leaders as well, we've seen this effort be successful in other programs such as smoking cessation. By promoting public transportation in areas without it, we can allow patients without access to reliable transportation a means to not only be compliant with treatment, but support employment and education. Expanding access to home health nursing and mental health services for people with addiction, we can promote functional parenting and the assimilation of healthcare into the community. By meeting patients where they are instead of expecting them to come to us, we can positively impact outcomes and help to prevent relapses before they occur. We know that addiction fundamentally changes the brain. The dissemination of information including SUD as a brain disease linked with lifestyle choices instead of solely poor decision-making can help to increase community awareness, acceptance, and further services efforts to impact the opioid epidemic. Targeted case management services should also be covered under insurance.
In addition, when evaluating alternative payment models, our office can be used as an example. We provide concierge-style medicine to patients with chronic conditions who are traditionally high utilizers. We are paid a flat rate per month to provide primary care, transportation services to our office and other healthcare providers, and therapy. We provide as much care out of our office for this flat rate and have 3 nurse practitioners, one LCSW, 2 transportation drivers, 2 nurses, and 2 health guides on staff to help patients learn healthier lifestyles and habits, be proactive in their own care, improve outcomes, and lower costs. Our model is unique and practices true patient-centered care. We accept almost exclusively Medicaid patients with a few Medicare and Medicare/Medicaid.

Michael Rust, President
Kentucky Hospital Association

The existing PATHways program at the University of Kentucky is a model program after which other programs focused on treatment of OUD in expectant and new mothers can provide comprehensive care. A separate letter to the Senator has been drafted by the leadership of this program**.**

Jacob Bast, Senior VP/COO
St. Elizabeth Healthcare

The science is clear: effective treatment for OUD is long term, especially for those people who have been using a long time or using high doses. Enabling long-term, evidence-based treatment though Medicaid and Medicare has the power to change the lives of individuals, their children and their families. Medicaid reimbursement for targeted case management in treatment facilities would increase the likely of treatment success. Adding targeted case management, life skills, and career development is part of recovery and should be part of a disease management plan.