Testimony for the

Senate Committee on Finance, Subcommittee on Health Care

United States Senate

Field Hearing on Opiate Abuse

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Chairman Toomey, Ranking Member Stabenow and members of the Senate Finance Health Care Subcommittee, I am submitting testimony on behalf of The Pew Charitable Trusts. Pew is an independent nonpartisan research and policy organization dedicated to serving the public. Pew's prescription drug abuse project works to develop and support policies that will help reduce the inappropriate use of prescription drugs while ensuring that patients with legitimate medical needs have access to effective pain management. Pew encourages Congress to pursue policy solutions to address the nation's prescription drug abuse epidemic. The Stopping Medication Abuse and Protecting Seniors Act of 2015 is one such proposal that has been introduced in by Senators Toomey (R-PA), Brown (D-OH), Portman (R-OH), Kaine (D-VA), and Casey (D-PA). Pew supports this bill, which authorizes the use of drug management programs in Medicare.

Our testimony makes two key points:

- The use of opioids for non-cancer pain among Medicare beneficiaries is common, with some patients obtaining these prescription from multiple prescribers and pharmacies—a factor that places these individuals at increased risk for overdose and other adverse events, and
- Medicare beneficiaries would benefit from drug management programs that allow plan sponsors to prevent inappropriate access to controlled substances that are susceptible to abuse and better coordinate patient care.

The drug management programs described in the legislation, which are also known as patient review and restriction programs (PRRs), can play an important role in preventing prescription drug abuse by assigning patients who are at risk for drug abuse to pre-designated pharmacies and prescribers to obtain these drugs. Through this mechanism, PRRs allow plan sponsors and providers to improve care coordination and prevent inappropriate access to medications that are susceptible to abuse. The effectiveness of PRRs has led to their adoption in the public and private sector, with major insurers operating these programs in their Medicaid managed care and employer-based plans. In addition, 46 state Medicaid programs currently operate PRRs.[i] An evaluation of state Medicaid PRR programs performed by a Centers for Disease Control and Prevention 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.[ii]

The need for these programs in Medicare is highlighted by the growing concern about potential overuse of opioids among these beneficiaries. Analyses conducted by the Medicare Payment Advisory Commission (MedPAC), the Centers for Medicare & Medicaid Services (CMS) and the Government Accountability Office (GAO) have sought to quantify the extent of opioid overuse in this population. A MedPAC analysis of 2012 prescription drug event data found that 10.7 million (87 percent) of the roughly 12 million Medicare Part D beneficiaries who were prescribed prescription opioids received these therapies for conditions not associated with cancer treatment or hospice care. Among beneficiaries with the highest expenditures for opioids used for these indications, 32 percent obtained these prescriptions from four or more prescribers and 32 percent used three or more pharmacies. MedPAC also found that these beneficiaries accounted for 68 percent of the program's total gross spending on opioids for non-cancer, non-hospice-related care. On average, these patients filled 23 opioid prescriptions at a cost of $3,500 per beneficiary.[iii]

Evaluations by CMS and GAO found similar trends in the use of opioids for non-cancer, non-hospice-related care and instances in which multiple prescribers and pharmacies were used to obtain these therapies, respectively.[iv,v] Further, the CMS analysis identified approximately 225,000 beneficiaries who received potentially unsafe opioid dosing, which was defined as doses that exceeded 120 mg daily morphine equivalent dose for 90 or more consecutive days.

The Stopping Medication Abuse and Protecting Seniors Act of 2015, which would authorize the use of PRRs in Medicare, would help reduce prescription drug abuse in this population. In addition, the legislation has strong beneficiary protections to ensure that patients with legitimate medical needs have access to effective pain management. Beneficiaries have the right to appeal their identification as at-risk and subsequent enrollment in a PRR. Patient input on the selection of prescribers and pharmacies will also ensure reasonable access, including consideration of geographic location, cost-sharing, travel time, and multiple residencies. Furthermore, patients receiving hospice care, those residing in long-term care facilities, and other beneficiaries the Secretary elects to treat as exempt would be excluded from enrollment in a PRR. This mechanism can be used to avoid enrollment of patients with medical diagnoses that require high doses or combinations of controlled substances to manage their pain.

There is substantial support to advance this policy as an effective tool to decrease opioid abuse. The policy has been proposed in the FY 2016 Budget request for the Department of Health and Human Services. A proposal similar to the Senate bill is part of the 21st Century Cures Act, which passed the House of Representatives with broad bipartisan support on July 10, 2015.

We urge the Senate to help address the nation's prescription drug abuse epidemic by passing legislation that would authorize the use of PRRs in Medicare. We look forward to working with Congress to refine the Stopping Medication Abuse and Protecting Seniors Act of 2015 and other legislative proposals that would expand use of the PRRs to ensure that these programs work as intended to prevent prescription drug abuse in Medicare.

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[i] Roberts AW and Skinner AC. Assessing the present state and potential of Medicaid controlled substance lock-in programs." *J Manag Care Pharm*. 2014;20(5):439-46c.

[ii] Centers for Disease Control and Prevention; National Center for Injury Prevention and Control (2012). Patient review & restriction programs. Lessons learned from state Medicaid programs. Available at http://www.cdc.gov/homeandrecreationalsafety/pdf/PDO_patient_review_meeting-a.pdf

[iii] Medicare Payment Advisory Commission (2015) .Medicare and the Health Care Delivery System, Report to the Congress. Chapter 5. Available at http://www.medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0

[iv] Centers for Medicare & Medicaid Services (2013), Supplemental guidance related to improving drug utilization controls. Correspondence from Cynthia G. Tudor, director, Medicare Drug Benefit and C and D Data Group dated Sept. 6, 2012. Available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/HPMSSupplementalGuidanceRelated-toImprovingDURcontrols.pdf

[v] Government Accountability Office (GAO) (2011) Medicare Part D: Instances of questionable access to prescription drugs," Report to Congressional Requesters. Available at http://www.gao.gov/assets/590/585424.pdf