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PRESCRIPTION DRUG ABUSE: HOW ARE MEDICARE AND MEDICAID ADAPTING TO THE CHALLENGE?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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PRESCRIPTION DRUG ABUSE: HOW ARE MEDICARE AND MEDICAID ADAPTING TO THE CHALLENGE?

THURSDAY, MARCH 22, 2012

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:01 a.m., in room SD–215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Present: Senators Schumer, Grassley, and Cornyn.

Also present: Democratic Staff: Jocelyn Moore, Staff Director; and Sarah Dash, Health Legislative Assistant. Republican Staff: Rodney Whitlock, Health Policy Director.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE

Senator ROCKFELLER. Good morning. Others will be coming. Senator Cornyn is here. The eminent senior Senator from Iowa is here.

Senator GRASSLEY. Thank you.

Senator ROCKFELLER. He will have to depart for 10 minutes to go do his duty as ranking member of the Judiciary Committee but will be back, he said, to ask particularly difficult questions.

We are going to be talking about an epidemic of drug abuse, which is actually—this is such a timely hearing, and I know there are lots of hearings of this sort. But it is such a terrible problem in my State, and I suspect in all of our States. It is tragic, it is sad, it is needless, it is fraudulent, it is horrible, and it is costing so much needless money that could be spent elsewhere.

So it is just the epidemic of drug abuse. Simply put, prescription drug abuse is what happens when people use prescription drugs for non-medical purposes, slipping into it sometimes without even knowing it. Opioid painkillers, antipsychotics, or stimulants are the ones that are most commonly used, but there are many others.

The Centers for Disease Control has termed prescription drug use as an "epidemic." I do not think they have done that—well, I guess they did in 1918, with the Great Influenza Epidemic, but they do not do it on a regular basis. And it is—it is a horrible problem.

Overdose from prescription painkillers is now one of the leading causes of accidental death in the United States. In my State, which

is rural and not particularly wealthy, just between the years of 2001 to 2008 the number of deaths from this kind of death went up 4 times. Why 4 times? I do not know. That is what we are going to talk about.

And for every death, the CDC tells us there are 10 treatment admissions of abuse for what we are talking about, 32 emergency room visits, 130 people who abuse or are addicted to these drugs, and 825 non-medical users. There is no single solution, obviously, for all of this, but we cannot take that as a reason not to get at it. Today we will hear some stories that might shock and sadden us, but we will also hear some practical solutions. We will be hearing those from you.

Prescription drug abuse is not just about some sensational thing that happens to celebrities like Michael Jackson—if you considered him a celebrity; I am not sure I did—who died before their time from tragic overdoses.

The fact is, prescription drug abuse touches people from all walks of life. It is about an ordinary person, like a polite, stoic, 79-year-old man from Clay County, WV.

Senator GRASSLEY. Clay County, IA.

Senator ROCKFELLER. You have a Clay County?

Senator GRASSLEY. Yes.

Senator ROCKFELLER. Well, maybe he was from there.

Senator GRASSLEY. Maybe he was.

Senator ROCKFELLER. Well, it ends in a happy way, so probably it was Iowa rather than West Virginia. But he could not be here today because he has to stay home to take care of his wife. He was going to testify. She is partially paralyzed. His story, untypically, ends well, thanks to the primary care doctor that he visited.

When she asked why the man was taking such a powerful opioid painkiller, he said very simply that he had a lot of back pain from lifting his wife day after day. So his doctor took him off the drugs, and it turns out this man has been addicted without even realizing it. Now that he is off the powerful painkiller, he is more clear-headed and without all the side effects, and he has been feeling well, better than he has for a long time. Untypical story. It is an untypical story.

Now, of course, the prescription drugs can, and do, work wonders for millions of people. For people with conditions like chronic pain or severe mental illness, prescription drugs can be a godsend. But the availability of powerful prescription drugs has in some ways gotten ahead of our ability to prescribe them safely.

Prescribers do not have the tools they need. They do not have, sometimes, the education in medical schools focused on this. Prescription drug monitoring programs—is that a mystery to doctors or is that something that all of them know? These things work across State lines. Patients need to be better educated. That is easy to say, but so hard to do because they react to their pains.

Sadly, because prescription drug painkillers, stimulants, and antipsychotics are so powerful and so addictive, they are all too often the target of criminals. These criminals are worse than ordinary fraudsters. They not only steal taxpayer dollars through fraudulent schemes like pill mills or fraudulent prescriptions, they

also feed on people's addictions and prey on the pain. Obviously this is not right.

But prescription drug abuse is not limited to fraud. We do ourselves a disservice if we ignore the significant clinical implications of this problem. So today we will hear from our expert panel—and you are that—about the range of solutions that we can implement in Medicare and Medicaid, a subject which the two of us have a lot of interest in, and this committee obviously does.

You will help us answer important questions such as, what tools and support systems do doctors, nurses, and other prescribers need to make sure people get the right care when it comes to controlled substances? How can Medicare and Medicaid help educate patients and coordinate care so that prescriptions are used correctly? Are we adequately identifying people at risk of addiction to controlled substances? Are there new models of treatment we should consider testing in Medicare and Medicaid, always trying to do the right thing and give people treatment and not waste money? Can existing fraud detection systems tell us the difference between deliberate fraud, addiction-driven behavior, and uncoordinated care that leads to beneficiaries obtaining the prescriptions from multiple sources?

So there is a lot to learn today, and you all are incredibly wise and gifted, and we are very honored that you have taken the time to be with us.

[The prepared statement of Chairman Rockefeller appears in the appendix.]

Senator ROCKFELLER. At this point I will call upon my distinguished friend, Senator Charles Grassley from Iowa.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Well, I thank you for holding this hearing. I appreciate your leadership on this issue.

Let me give you two measures of why we ought to appreciate your leadership on this issue. Number one, the Office of National Drug Control Policy describes prescription drug abuse as "the Nation's fastest-growing problem." The Centers for Disease Control and Prevention has classified prescription drug abuse as an "epidemic." According to the most recent National Survey on Drug Use and Health, a survey conducted by HHS, roughly 2.5 million people aged 18 and older used prescription drugs non-medically for the first time in 2010. This averages out about 6,000 people per day abusing prescription drugs just for the first time.

For Iowans, prescription drugs account for the fastest-growing form of substance abuse. Overdose deaths in Iowa from non-medical use of hydrocodone and oxycontin pills have increased 1,233 percent since the year 2000. Over-prescription of these types of drugs strains the financial viability of Medicaid and Medicare systems and threatens the health and well-being of our people.

As health care payers, Medicare and Medicaid have a significant role to play in guiding solutions to this growing problem. To highlight how much of an impact prescription drug abuse has on Medicaid, I want to tell you about an ongoing investigation of mine.

In 2010, I sent a letter to all 50 State Medicaid directors, asking them for their top 10 prescribers of the top 8 most over-prescribed drugs on the market. Many States provided the data I requested, and statistics are alarming.

For example, in Maine, the top prescriber of Oxycodone wrote 1,867 prescriptions in 2009, nearly double the number of prescriptions of the second top prescriber. The same provider wrote 1,723 prescriptions of Roxicodone, nearly 3 times the number of the other two top prescribers.

In January, I followed up on this information and wrote again to all 50 States, requesting updated data and asking the States what, if any, action they took with the top prescribers, and what systems they had in place to prevent excessive prescribing from taking place.

I also asked what, if any, training or guidance CMS has offered the States in preventing prescription drug abuse from occurring. While the responses from the States are still being received, many States are still reporting a selection of top 10 providers who are prescribing at rates double or triple that of peers.

While some of these outliers are legitimate providers working in high-volume practices such as mental hospitals, many cannot be explained. For example, the top prescriber of antipsychotics in Nevada wrote nearly 6,800 prescriptions for drugs over the years 2010 and 2011, more than 10 times some of the other top prescribers identified. For context, no individual prescriber in Colorado wrote more than 2,000 prescriptions for the same drug over the same period. This single doctor in Nevada accounted for $2.75 million in payments from the Medicaid system.

As a result of my request, South Carolina has investigated 34 of 83 providers who appeared on those lists for possible Medicaid abuses. South Carolina's investigation resulted in the repayment—repayment—of nearly $1.9 million that more than 30 of the health care providers inappropriately billed to the State Medicaid agency.

Texas has opened investigations into dozens of prescribers identified in the list, making several referrals for criminal prosecution to the State licensing board. California, Wisconsin, Tennessee, Nevada, New Hampshire, Minnesota, Kansas, Hawaii, and even my State of Iowa have taken similar actions against prescribing outliers in their Medicaid programs.

The steps taken by these States highlight the aggressive role that each and every State should be taking in monitoring and investigating prescription drug practices in the Medicaid program. Further, States have overwhelmingly confirmed that CMS has been an absent partner in helping to lower prescription drug abuses in Medicaid.

I look forward to hearing from our witnesses today about what steps physicians, hospitals, States, and the Federal Government could be taking to curb abuse of prescription drugs. Not only should we put an end to the lives lost for over-prescribing drug abuse in Medicare and Medicaid, we should be working collaboratively to find meaningful solutions. The cost of doing nothing is too high already.

Thank you.

Senator ROCKEFELLER. Thank you, Senator Grassley. I read your study, and it is excellent.

Senator GRASSLEY. Well, thank you.

Senator ROCKEFELLER. It is excellent.

Senator GRASSLEY. Thank you.

[The prepared statement of Senator Grassley appears in the appendix.]

Senator ROCKEFELLER. Senator Cornyn, you may have a statement, but more importantly you may have somebody you wish to introduce.

OPENING STATEMENT OF HON. JOHN CORNYN, A U.S. SENATOR FROM TEXAS

Senator CORNYN. Thank you, Mr. Chairman. I do, and I will take no more than 3 minutes. But I want to thank you for convening this very important hearing on a very serious topic, and Senator Grassley for his leadership in investigations.

But I want to introduce Billy Millwee, who is one of the witnesses here from my State of Texas. Mr. Millwee serves as a Deputy Executive Commissioner for Health and Human Services Operations at the Texas Health and Human Services Commission. Since January of 2010, he has been the Texas Medicaid Director.

He received his bachelor of science degree in business administration from the University of Maryland, a master's of science in health care administration from Central Michigan University, and a master of arts and sociology from Texas State University.

The Texas Medicaid program, I trust Mr. Millwee will explain, has made great strides in addressing over-utilization of drugs on the front end and on the back end. Both are critically important for stemming this growing trend of prescription drug abuse, which unfortunately is the Nation's fastest-growing drug problem. It is also a fiscal problem for the States and for the Federal Government because of the burgeoning costs associated with Medicaid.

Using edits at the point of sale, pharmacists are able to catch potential problems, and HHSC is working to educate physicians about prescribing patterns that are outside the norm.

I want to specifically thank Mr. Millwee for his efforts following Senator Grassley's request to identify the high-volume prescribers of certain often-abused drugs. Texas responded with immediate action which has led to Medicaid exclusions and investigations.

As a former State Attorney General, I appreciate the close collaboration Mr. Millwee has had with Attorney General Greg Abbott and his office in these investigations and litigation. These are proactive steps that will go a long way toward curbing this disturbing epidemic of prescription drug abuse.

These are just a few of the proactive things that Texas is doing. I look forward to hearing more about them in detail from Mr. Millwee and hope he can help inform this committee—as will the other witnesses, no doubt—on things we can do to address this problem.

Mr. Chairman, as you know, all of us have multiple committee assignments that may take us in and out. Thank you for your courtesy and for your leadership.

Senator ROCKEFELLER. No, thank you. Thank you very much, Senator.

First, all of you have biographies, and it is just criminal to introduce a person with a few short sentences without talking about all that you have done, where you have been to school, and this, that, and the other thing. But for the sake of brevity, I have to do that.

First is Dr. Jeffrey Coben, who, happily, is director of Injury Control Research Center at West Virginia University in Charleston. Well, it says here Charleston. I thought maybe you were at the hospital there. Well, I know where WVU is, but it has branches. So, I apologize.

First, I would like to extend that welcome to you. You are a practicing emergency medicine physician and have conducted research on prescription drug overdoses. We would like very much to hear what you have to say.

STATEMENT OF JEFFREY COBEN, M.D., DIRECTOR, INJURY CONTROL RESEARCH CENTER, WEST VIRGINIA UNIVERSITY, MORGANTOWN, WV

Dr. COBEN. Thank you, Mr. Chairman. Chairman Rockefeller, Ranking Member Grassley, and distinguished subcommittee members, thank you very much for inviting me to discuss this critically important issue.

The alarming increase in prescription drug abuse is clearly a crisis that demands our attention, but the statistics and the numbers do not adequately describe the ravages of prescription drug abuse. As a practicing emergency physician, I have seen the pain and torment of families who have lost a family member from overdose; I have seen children removed from their homes; and I have seen shootings, stabbings, and suicide all as a direct consequence of prescription drug abuse.

I can also attest to the benefits of prescription opioid analgesics, and I think anyone here who has suffered with a painful condition can probably provide their own commentary. In fact, in many cases, providing adequate pain relief can be the best, or only, thing that we as health care providers can do for our patients.

Fifteen years ago in this country, physicians were being heavily criticized for not adequately addressing pain. Now, only a short time later, we are faced with a rising epidemic of prescription drug overdoses, fueled in part by a dramatic increase in the sale of these strong painkillers.

Balancing the appropriate use of prescription drugs with efforts to prevent their abuse is a complex and difficult challenge, and addressing this problem will require a multi-factorial approach. For example, we need to address societal attitudes towards the recreational use of prescription drugs.

The majority of teens in this country believes that using an opioid medication without a prescription does not pose a great health risk. We also need to do a better job educating health care providers on the broader use of pain management, opioid prescribing guidelines, and on the best approach to screen and refer patients with substance abuse problems.

Efforts to improve, standardize, and facilitate the more widespread use of prescription drug monitoring programs are also need-

ed. There is, of course, a critically important role for law enforcement and the DEA in detecting and intervening with illegal efforts to obtain and distribute prescription drugs.

Focusing now more specifically on public insurance programs, there are several strategies I think that need to be considered. These include the expanded use of real-time analysis of claims data to identify potential cases of doctor shopping and other forms of abuse; the expanded use of drug utilization reviews, particularly those that can be implemented at the point of sale; and the expanded use of single-provider/single-pharmacist lock-in programs for individuals who have been identified as abusers.

Medicare and Medicaid have also had an important role in promoting the use of electronic health records and e-prescribing. These systems have great potential for not only reducing fraudulent prescriptions, but also for identifying potentially lethal combinations of prescription drugs.

Many State Medicaid programs have also been at the forefront of efforts to promote the use of the patient-centered medical home model of primary care. The medical home model has the potential to also help curb the problem of prescription drug abuse by promoting better coordination of care.

We must also, I think, recognize the important role for substance abuse treatment, and the very real and critical shortage of treatment service availability throughout the country. Providing beneficiaries with coverage for treatment and reimbursing providers for screening is another important role for Medicaid programs.

Finally, we need to consider the drugs themselves. Safer and equally effective pain relievers can be developed, and tamper-proof drug dispensing units can limit the quantity of medications available. As these products increasingly come to market, both Medicare Part D and Medicaid programs will need to consider the potential benefits and costs of adding them to their formularies.

Approximately 50 years ago, the United States was experiencing a similar dramatic increase in deaths, this time from motor vehicle trauma. We responded by developing a wide array of interventions that have been integrated, systematic, and sustained. The result has been a great success story. In the first decade of this century, while the poisoning death rate has climbed by 130 percent, the motor vehicle death rate has dropped by 25 percent.

As we now confront the problem of prescription drug abuse, a similar integrated and sustained strategy is needed. While regulations and other approaches involving Medicare and Medicaid cannot solve this problem alone, they can certainly play an important role.

Thank you.

Senator ROCKEFELLER. Thank you, Dr. Coben. That calls for some questioning.

[The prepared statement of Dr. Coben appears in the appendix.]

Senator ROCKEFELLER. Dr. Timothy Schwab. Welcome to you, sir. Dr. Schwab manages pharmacy and medical informatics and sets medical policies for SCAN Health Plan, which is a Medicare Advantage plan serving more than 128,000 members in California, I would guess.

So, we welcome your testimony, sir.

STATEMENT OF TIMOTHY SCHWAB, M.D., F.A.C.P., CHIEF MEDICAL OFFICER, SCAN HEALTH PLAN, LONG BEACH, CA

Dr. SCHWAB. Thank you, Chairman Rockefeller, Senator Grassley, and members of the committee. My name is Tim Schwab. I am chief medical officer of SCAN Health Plan in Long Beach, CA. I am a board certified internist and have been working at SCAN for nearly 25 years. I have been very active in geriatric programs, academic programs, and California State policy committees looking at seniors, people with disabilities, and individuals eligible for both Medicare and Medicaid. I appreciate the opportunity to appear before you today to discuss the innovative programs SCAN has in place to protect our members from the dangerous effects of prescription drug abuse.

SCAN Health Plan is the fourth-largest not-for-profit Medicare HMO in the country. We primarily serve seniors who have multiple chronic conditions and/or frailty. We have served this population since 1985, with the mission to help seniors maintain their health and independence. SCAN has always provided a strong geriatric-focused pharmacy benefit for our members.

I would like to share with you a composite that illustrates many of the medication challenges being faced by SCAN beneficiaries, our providers, and payers.

Ms. J is an 81-year-old member who is widowed and lives alone in a senior independent living unit. She has a longstanding history of diabetes, high blood pressure, atrial fibrillation, and severe osteoarthritis. She had a stroke 5 years ago and has some residual right-sided weakness.

This weakness, in addition to her severe arthritis, limits her mobility and activities. Her diabetes has caused reduced vision and impaired kidney function. Despite these challenges, she is still able to live alone, and take care of herself.

Prior to joining SCAN, Ms. J was on eight regular medications, plus occasional sleeping pills. She was seeing three different specialists in addition to her primary care physician. She utilized three different pharmacies. During the previous year, she had six emergency room visits for increasing pain, two for falls, and she was hospitalized twice.

When a new member enrolls in SCAN, we conduct a comprehensive risk assessment. We flagged Ms. J to be at high risk for hospitalization given her history. She was referred to our geriatric health management team for further evaluation.

Our interdisciplinary team—a geriatric care manager, a geriatrician, and a geriatric pharmacist—identified the following issues: poly-pharmacy with several medications from the same therapeutic class, potential drug-drug interactions, potential dosage adjustments needed to compensate for her reduced kidney function, and a high risk of falling due to medications affecting her gait and balance.

So we contacted Ms. J's physicians. We found they had little awareness of all the different medications that she was being prescribed from the different physicians. They were unaware that several of those medications were causing her falls and emergency room visits. Those medications were changed at that time.

Her primary care physician then referred her to a pain management specialist. Her pain is now much better controlled, and she has had no emergency visits in the last year. Her assigned care manager, a nurse, continues to regularly talk to her and to her primary care physician to make sure her pain is being managed to her satisfaction and that she is experiencing no other untoward medication effects.

Ms. J, who represents so many of the frail elderly, has benefitted from a model of care that focuses on the specific needs of the geriatric population. SCAN has developed a very patient-centric geriatric model that utilizes individual assessments, utilization data, and pharmacy data to identify and create early interventions for pharmacy management. These include: real-time edits at the pharmacy to identify and notify the physician of dosage errors and drug-drug interactions; medications not to be utilized in the geriatric population; inappropriate early refills; identification of same or similar medications filled at different pharmacies and different prescribers of the same medications; a medication therapy management program for poly-pharmacy; geriatric continuing medical education for physicians, nurses, pharmacists, and case managers on specific geriatric conditions; and pharmacy management. This program also includes a module on pain management.

Drugs can ease pain and prolong life, but we must make sure that what is meant to help does no harm. We take that mission very seriously at SCAN. Thank you.

Senator ROCKEFELLER. Thank you, Dr. Schwab, very much.

[The prepared statement of Dr. Schwab appears in the appendix.]

Senator ROCKEFELLER. I am going to skip over to Mr. Millwee. You have been introduced already, and you have a very distinguished history. You are the Medicaid Director of the State of Texas.

Mr. MILLWEE. Yes, sir, I am.

Senator ROCKEFELLER. Yes. So we would like to hear what you have to say, sir.

STATEMENT OF BILLY MILLWEE, M.H.A., STATE MEDICAID DIRECTOR, TEXAS HEALTH AND HUMAN SERVICES COMMISSION, AUSTIN, TX

Mr. MILLWEE. Well, good morning, Chairman Rockefeller, Ranking Member Grassley, committee members. My name is Billy Millwee, and I serve as the Texas Medicaid Director. I am very honored to be with you today to talk about what Texas is doing to address prescription drug abuse in Medicaid.

The approach in Texas is one of collaboration. We have worked with the various Health and Human Services agencies. It is not just a Medicaid issue; it is an issue around our Health and Human Services agencies that we need collaboration to address. It involves the Texas Attorney General as well as the provider community. That collaboration has developed into a comprehensive approach. The elements of that include prevention, education, intervention, treatment, and improved use of technology.

Let me cover each of those very briefly with you. Strategy one is prevention. Here is what I mean by that. Through our Medicaid drug utilization process, we employ both point-of-service edits and

prior authorization. The point-of-service edits look at the maximum quantities, early refills, and therapeutic duplication.

If those things are present, then we do not pay for that prescription. We do not allow that prescription. Prior authorization is used extensively for opiates and antipsychotics. Absent prior approval, if the clinical criteria are not met, then we will not fill that prescription.

Along the same lines of prevention, effective March 1, 2012, about 22 days ago, we implemented a managed care model for 3.5 million Medicaid clients. Not only do they get their health services through these HMOs or managed care, but also their prescription drugs. We believe that will result in improvements in utilization management and align the financial incentives as well.

We have made great progress in our foster care program. Texas, in conjunction with some leading physicians, has developed psychotropic medication utilization review processes for children in foster care. We implemented a State-wide managed care program exclusively for foster care children, and the managed care program includes a robust medical home—patient-centered medical home—electronic health passport, and intense utilization review using the guidelines I mentioned earlier.

The program has worked. Since 2005, we have seen a tremendous decrease in the use of psychotropic drugs in foster care children. Prior to the program, we had about 30 percent of the children in foster care receiving psychotropics. That has declined to about 20 percent today, and it is decreasing every year.

Strategy two is education. We use retrospective drug utilization review. We identify providers with high utilization patterns outside the norm. Those prescribers are sent education letters, with specific clients listed, and some clinical criteria that may apply. That program has been successful. We find generally that, 6 months after that intervention or education letter is sent, we see a 3- to 6-percent decrease in the utilization of that prescription for that particular provider.

Let me talk a little bit about strategy three, intervention. We have an Office of Inspector General that conducts data mining to identify and take action on providers, as well as clients. Of the high-volume providers identified in a 2010 letter from Senator Grassley, four have been excluded from the program, 39 are under investigation, three have been referred to the Attorney General for prosecution, and two have been referred to the licensing board for action.

For clients, we operate a lock-in program. We identify clients who have a suspected pattern of drug-seeking behavior. At first a notice is sent advising them that we have noticed these patterns in their use of drugs and offer some potential management solutions if they do not respond. Then they are put on a lock-in program and locked in to a particular pharmacy so that we can better monitor utilization.

Strategy four is treatment. During 2010, we implemented a Medicaid substance abuse treatment program. Treatment consists of outpatient as well as residential treatment. Services are provided by licensed therapists in appropriately licensed facilities. The re-

sults look promising. We believe that the cost of the program may well be paid for through savings in the program in other areas.

Strategy five is technology. We believe technology offers great promise. We implemented this year an e-prescribing process. We will soon deploy a Medicaid electronic health record so that providers can access information about clients with the swipe of a magnetic card and some other security precautions.

Texas is very active in promoting electronic medical records. Through our EMR incentive program, we have granted about $300 million over the past 2 years to providers to develop these electronic medical records.

We certainly can, and will, do more. We believe we have made some significant progress, and really we appreciate the work of this committee in bringing this issue to the forefront. When you shine a bright light on something, I think that is how you get it fixed.

Thank you very much.

Senator ROCKEFELLER. That should be the way we get things fixed. Then there is the problem of writing legislation, and trying to make it on a bipartisan basis and getting it past the Senate, and then getting the House to do something similar, then conferencing, and then having both houses vote on it, and then having the President sign it.

I mean, this is all very rigorous, but the dimensions are so shocking, and they are exploding right in front of us, as you all know better than—well, we all know too. So this is why your being here is so important.

[The prepared statement of Mr. Millwee appears in the appendix.]

Senator ROCKEFELLER. Alex Cahana, Dr. Cahana, is chief of anesthesiology and pain medicine at the University of Washington in Seattle. He is a specialist who promotes measurement-based care—I am interested in that phrase—as standard of care in pain medicine.

Welcome, sir.

STATEMENT OF ALEX CAHANA, M.D., CHIEF OF ANESTHESIOLOGY AND PAIN MEDICINE, UNIVERSITY OF WASHINGTON, SEATTLE, WA

Dr. CAHANA. Thank you, Chairman Rockefeller, Ranking Member Grassley. I would like to thank this committee for inviting me to discuss the clinical aspects of good pain management, but, more importantly, I want to tell you about the applied solutions that we have put in place at the University of Washington, and in the State of Washington.

I am pleased to report to you the very promising preliminary results of these interventions were significant reductions of deaths from opioids in the Medicaid population and the Worker's Compensation population.

I will preamble by saying that it is unfortunate that in the English language we use the same word for pain as a symptom and pain as a disease. Pain as a symptom is a by-product of a disease. Take care of the disease, the pain goes away. However, when pain becomes the disease, when there is nothing broken to fix, no infection to cure or tumor to operate upon, treating pain as if it was a

symptom simply does not work. It actually makes things worse. This is why we are seeing so much harm with high-dose prescription pain drugs.

To treat chronic non-cancer pain as a disease, a treatment plan may sometimes include opioids but always includes listening to the patient, determining what is interfering with his or her life, defining functional goals, and individually tailoring a variety of medical, exercise, mind-body treatments, and healthy life choices.

A large volume of material has been recently published, but there are a few things that need to be remembered. First, there is virtually no evidence that high-dose opioids relieve pain or improve function in chronic non-cancer pain.

Senator ROCKEFELLER. In chronic what?

Dr. CAHANA. Chronic non-cancer pain.

Senator ROCKFELLER. All right.

Dr. CAHANA. Second, there is growing evidence that shows that opioid treatments over 90 days are usually a commitment for life. Third, it is usually the most vulnerable, sickest, and disadvantaged patients like Medicare, Medicaid, and the veterans' population who receive the most opioids, oftentimes because that is what their health care professionals know, and what the insurance will cover.

Now, in the written material you will find seven solutions that we have put in place. In my opening statement I have time only to go over three, the three most important, and hopefully for the rest of the discussion we can go over the rest.

The first and most important is that measuring pain, mood, and function at each clinical encounter is key to understanding patients and the effectiveness of treatments. So, since November of 2008 at the University of Washington Pain Center, we have been using an assessment tool with every clinical encounter.

This tool allows patients to describe how pain impacts key domains of their lives, including pain interference to essential activities, status of their physical functioning, emotional well-being, satisfaction, and the potential risk for prescription opioid abuse and misuse.

Combined with routine urine drug tests, this model of measurement-based care informs clinicians about important patient characteristics, treatment progress, and overall satisfaction from the visit. It also permits us to decide on and identify exceptional outcomes, efficiencies, and needed resources for expansion of services to provide effective and efficient outcomes—not how to treat pain, but who to treat pain with what.

The second-most important solution is that, in order to increase the availability of specialty care, we initiated twice a week a 90-minute tele-pain provider-to-provider consultation.

This service, called ECHO—Extension for Community Health Outcomes—was developed at the University of New Mexico and is designed to improve access to specialty care for under-served populations with complex health problems. It uses video conferencing technology to train primary care providers to treat complex situations and has been shown already to be as effective and safe as specialty care.

Since March 2011, we have trained close to 1,500 professionals, with thousands of training hours, from 76 locations, with 40 to 50

providers dialing in at each session from Nome, AK all the way to Pocatello, ID. We have documented an improved sense of knowledge of prescriptions among our providers, and an even higher decrease in mortality rate in counties receiving education compared to the State average.

Last, since 2010, we have provided a second opinion consultation for Medicare and Medicaid beneficiaries receiving ultra-high doses of over 1,000 milligrams of opioids equivalent a day. This follows the model of the second opinion consultation which was developed for children treated with antipsychotics, which was shown to improve patient outcome and be a cost benefit.

We started a targeted mentoring program for top prescribers, and it is called Look Over the Expert's Shoulder, which is a postgraduate educational program allowing advanced training and certification in the communities of practice. Look Over the Expert's Shoulder-trained pain champions are expected to serve as educators, leaders, and resources in their communities where specialty pain clinics are unavailable or inconvenient due to excessive distance.

In summary, over-reliance on opioids is poor pain management and it is a result of, yes, insufficient provider training and patient education, but more so the lack of accessible real-time, patient-reported outcomes for the prescriber to tell, are these prescriptions or other treatments effective and safe? There is a presence of strong financial incentives to over-prescribe, over-proceduralize pain complaints, especially in the vulnerable population.

I urge the committee to consider these three elements to improve outcome. Thank you.

Senator ROCKEFELLER. Thank you very much, Dr. Cahana.

[The prepared statement of Dr. Cahana appears in the appendix.]

Senator ROCKEFELLER. I am going to turn, first, to Senator Grassley because he has to give a speech. Are you addressing the Pentagon, or the President, or who?

Senator GRASSLEY. No, my fellow colleagues.

Senator ROCKEFELLER. Oh, your fellow colleagues. All right. [Laughter.]

He has to leave, so I want him to have a chance to ask some questions.

Senator GRASSLEY. I do not think it is anything you would disagree with. Thank you for the courtesy.

The first question: Dr. Schwab, in your testimony you talked about the system SCAN has in place to weed out potential problematic prescribers, including physicians, dentists, physician assistants, and nurse practitioners. I want to applaud SCAN. However, it is not enough just to identify these prescribers. That information has to be shared.

For example, look at the recent case in Texas where a practitioner—one practitioner—defrauded Medicare and Medicaid of $375 million. He had already been disciplined by the Texas board. He had to surrender his controlled substance permit due to inappropriate prescribing. He was sanctioned for unprofessional conduct, yet he was still able to bill Medicare and Medicaid.

Now, the general public is going to wonder, how could that be? But it is. So, when you identify a bad practitioner, do you pass on that information to both the State in which the prescriber is licensed and to CMS? If not, why not?

Dr. SCHWAB. The answer is "yes." If we have identified that person and, after due diligence and discussing that with the provider, we have determined that there still is a problem, that information is turned over both to the State licensing board and to the Federal databank.

Senator GRASSLEY. All right.

And for the director from Texas, does Texas also pass this type of information on to CMS?

Mr. MILLWEE. Yes, sir, we do. We disclose our investigations, once they are completed, to CMS and also to our Attorney General.

Senator GRASSLEY. All right.

Well, thank you very much. It seems like the steps that both SCAN and Texas are taking ought to be recognized as being admirable and effective, and a pattern for everybody else. If we could learn to coordinate with all the players in the system, I am confident that we could do a better job of not only reducing drug abuse, but also waste and fraud in our two Federal programs.

For Dr. Cahana, in response to my letter to the States about their top prescribers of pain management drugs, I have begun to receive information. Some States have improved over previous years and some, despite their best efforts, have not.

An example is Florida. One doctor wrote nearly 7,000 prescriptions for Oxycodone HCL in 2010 alone. This doctor holds himself out to the public not as a pain specialist, but rather as a pain medicine specialist.

Dr. Cahana, is 7,000 prescriptions in 1 year unusual, in your experience? Also, before you answer that, are you surprised, given the advances in recent years to reduce prescriptions of these opiate-based painkillers, that a doctor is so blatantly holding himself out to the public as a ready and willing prescriber of these drugs?

Dr. CAHANA. We are always attracted by the outliers and the excessive activities of either patients or providers, and one of the problems that we see is education and the lack of a clear statement of what is the education knowledge base that is necessary to actually handle these type of prescriptions.

I think that using video mentoring, and making sure specialists reach out to these prescribers in the community, and providing them the latest information can transform them from outliers to pain champions, to actually have them in the community and say, you can help and give patients the feeling that specialists in tertiary care settings can give them a shoulder and a hand.

Senator GRASSLEY. This will have to be my last question, so my last one would go to Director Millwee.

On January 1, I sent letters to all 50 States requesting data on their top 10 prescribers. I also asked if CMS had provided the State Medicaid departments with any training or guidance to help identify potential issues with prescription drugs. Most Medicaid directors responded that they had not received any such training.

If there were more open communication and collaboration between States and the Federal Government, we would have a better

outcome for patients and taxpayers, States, and the Federal Government.

So, in your case, has the Texas Medicaid department received any training from CMS? Let me add to that, do you think any of the successful programs that Texas has implemented could have been enacted sooner if CMS had offered guidance?

Mr. MILLWEE. No, sir. We have not had any discussions with CMS about this issue. I think that potentially it could help, particularly if States develop these innovative ideas. If CMS could share those ideas among all the States, then there is some opportunity there to leverage what other States have learned and maybe put it in place faster.

Senator GRASSLEY. Thank you.

Thank you, Mr. Chairman, for letting me go ahead.

Senator ROCKEFELLER. Well, give a good speech.

Senator GRASSLEY. All right. I will. You know how that goes. [Laughter.]

Senator ROCKEFELLER. Senator Schumer, we welcome you. If it is all right with you, I would like to ask a question or two, then go right to you.

Senator SCHUMER. Of course.

Senator ROCKEFELLER. This is really to Dr. Coben and Dr. Cahana, but really could be to any of you. But it is so mystifying. What we are talking about is pain prescription medicines, and we are not even mentioning any of the other addictions: meth, or anything else that is just disintegrating families, communities, States, and ruining budgets, and much more importantly, ruining lives.

Dr. Coben and Dr. Cahana, are some people actually sort of under-treated for pain while some people are being over-treated for pain? How can these two things exist? Which may lead you to talk about what you get taught when you go to medical school.

Dr. COBEN. Senator Rockefeller, yesterday I worked in the emergency department before coming here, and, during the course of that 8-hour shift, I can probably recall at least half a dozen patients who were struggling one way or another with pain issues, and with medication issues. Part, I think, of that problem is the fragmented primary care system, and that patients are seeking out relief wherever they can obtain it.

Now, clearly some patients are seeking prescription medications for the purposes of the drug itself, but I think just as frequently patients are seeking care for the pain that they have, and not the recreational use of the medication. This fragmented care is really contributing, I think, quite a bit, which is why the coordination of care is so important.

To your point, I think there are clearly situations where there is under-prescribing, and physicians, for many, many years, have worried about the dangers of getting patients addicted to medications. But finding that balance and—as Dr. Cahana has spoken eloquently of and I am sure will talk more about in terms of measuring it and being able to understand what patients need at the time of care—having that information in front of us is a critically important contributor to how we can do a better job of matching the need with what we provide to patients.

Senator ROCKEFELLER. I am going to follow up on that.

Dr. Cahana?

Dr. CAHANA. Thank you, sir, for this question. Obviously, we are finding out that there are biological reasons for how something that was designed to be a very potent and reliable pain reliever under certain conditions actually increases pain and causes a whole host of untoward side effects that we were not aware of.

The problem with the over-prescription in certain conditions, which is a certain way of under-treatment by over-treatment, is that pain pills are not a panacea. There is an over-reliance embedded culturally on thinking that existential suffering can, and should, be treated by pills and devices. But what we are finding out is that other treatments, as I mentioned in my opening statement—healthy life choices, smoking cessation, weight reduction, integrative medicine—all these low-tech approaches to better health are turning out to be very promising. So, in order to determine what works—we say, does this work? yes? no?—it is important to measure at each clinical encounter what is going on.

When you come to my office, then you fill out a battery of questionnaires that allows me to see what you think about your pain, and are you sad, or are you anxious, or are you frustrated, and in that brief conversation I am able to very quickly concentrate on what things that you think are important.

So we are moving away from how to treat pain to whom to treat, with what, and what are the best treatments and not saying this is good or this is bad.

Senator ROCKFELLER. Can people sometimes declare to you that they have pain, but what you know is that somehow it is in their—not imagination, but they have decided they have pain because perhaps they had pain a week ago, and then there was a little sort of something that reminded them that that occurred. So my question really would be about people who really do have pain and need to be treated as opposed to people who are so accustomed, in their own minds, to having pain that they seek out medication just as a stabilizer for general purposes.

Dr. CAHANA. So, first of all, when we say "pain is in the head," it is to some extent accurate because pain is in the brain, and the only way of not having pain is not having a brain. But pain is not felt by the brain; pain is felt by people.

People express that in combination with what is going on in their life. This is why we call it the bio-psycho-social model that has biology in the brain, it is genetic, but also has our psychological characteristics and our traits as individuals, and then afterwards what life has given to us and how we are adapting to our current circumstances.

So every patient who comes and complains about pain, they are not imagining or inventing it; they are in true distress. The point is, what is the correct treatment that would help them out to relieve that distress and improve function? So it is not the pain, per se, that we are interested in, it is the functional recovery.

So if, for example, I look at a cohort of patients, and I look at just how many opioids did they use, and I look before treatment and after treatment, and I do a total average of totals, I will see that, after seeing me, they have reduced maybe their consumption by 3 percent. That is not very successful.

So why are we doing all this investment for a 3-percent reduction? But if I start to stratify patients into different groups, I will see that I have three types of patients. I have those who are well-engaged; they want to get better but they just do not know how. Then I have a group of minimally engaged patients. They are upset, they do not know, they are not sure that they want to, or can, get better. Then I have a group of patients who are fine. They do not see a problem. They do not understand what the problem is.

So, when we look at the well-engaged patients, we see reductions of up to 56 percent in opiod consumption, whereas in the other two groups you do not see those reductions. So it is clear that the first group coming to us has the right address for them.

For the second group, perhaps intensive counseling, mental health services would be the better thing to do.

For the third, if they are fine and they are stable, then there are maintenance programs and addiction medicine specialists that can continue to work on their health. So it is very important to be able to not talk about how to treat pain, but whom to treat, with what, and what are the alternatives.

Senator ROCKFELLER. Thank you, sir.

I call on Senator Schumer.

Senator SCHUMER. Well, thank you. I want to thank Chairman Rockefeller for holding a hearing on this critical issue. The crisis of prescription drug abuse is shocking. In New York, our law enforcement officials believe it is the greatest drug problem we have now, greater than crack or cocaine or heroin, and growing at clearly the most rapid rate.

We have seen all kinds of suffering in New York. There was a horrible incident in Seaford, Long Island, where an off-duty ATF agent was fatally shot when he was trying to intervene in a robbery of a local pharmacy. Another time in Medford, Long Island, where there seems to be a growing problem, four people, including an on-duty pharmacist, were murdered during a robbery of a pharmacy.

So we have to change the course of this epidemic. One of the reasons I am so glad that Senator Rockefeller has had the hearing, and I am proud to co-sponsor his bill, is I remember crack and even crystal meth, where we did not do enough early on, and it got its tentacles in our society, both of those drugs, and it took a long time to get them out. But we can stop that if we really move quickly here.

So the reason I like Senator Rockefeller's bill is because we need these painkillers, as you all stressed, but we do not want them to get into the wrong hands. The only way we are going to get after this is if we can identify patients who are doctor shopping and wasting taxpayer dollars through Medicare and Medicaid. That is not the only way, but that is an important way. We have a group in our State called Physicians for Responsible Opioid Prescribing. The group includes non-physicians, and it is doing good work. So there is a lot to do here as this bill moves along. I hope we can move it quickly.

So I have a few questions in the remainder of my time. I thank you for coming. Thank you. I care a lot about this issue.

Senator ROCKEFELLER. No, you go right ahead.

Senator SCHUMER. The first question I have is, how much of the problem is over-prescribing? CDC found, from 1997 to 2007, that the milligram-per-person use of prescription opioids in the U.S. went from 74 milligrams to 369. That is a 400-percent increase. In 2000, retail pharmacies dispensed 174 million prescriptions for opioids, and 257 million by 2009, up 48 percent.

So would any of you want to comment on how much of the crisis is over-prescribing?

Dr. CAHANA. I would like to say that, absolutely, when we look at prescription trends, also in other countries, we see that it is specific to what I would call the impoverished dialogue that we have with our patients. When you walk into my office for a follow-up and I have only a few minutes and I say, how are you doing, sir, and you go like this with your head, then the first thing I do is I look at the clock behind you and I say, all right, I have a few minutes. What are you taking? Here, take a little bit of this. So, prescription has become the passport to continue our day. I am saying this in the most constructive way.

Senator SCHUMER. Right.

Dr. CAHANA. It is something that we are incented to do, it is something that we are taught to do. For many of us, it is something that we believe is the right thing to do.

Senator SCHUMER. Right.

Dr. CAHANA. But very quickly, we find ourselves escalating on doses that we have no exit strategy for. Like I mentioned in my opening statement, if you are more than 90 days on these prescription drugs, then probably you are committed to life for that. I am sure that if that would have been the discussion when we started, then we would have a different decision in place.

Senator SCHUMER. Anyone else?

Dr. COBEN. Senator, if I could also comment.

Senator SCHUMER. Dr. Coben?

Dr. COBEN. Thank you. You mentioned the dramatic escalation since 1997. I think it is difficult to quantify exactly how much of this is over-prescribing. However, clearly there is some, but I will remind folks that in 1997, there were some guidelines and recommendations that were put forth saying that physicians were not adequately prescribing, and calling for increasing in prescribing of medications at that time. So I think some of that has been a response. Now, we clearly have swung too far in the opposite direction, so finding the appropriate middle ground is what we really have to concentrate on.

Senator SCHUMER. Did you want to say something, Dr. Schwab?

Dr. SCHWAB. Yes. I agree with both of my colleagues. I think, though, that especially in the Medicare population that I represent, the problem is inappropriate prescribing a lot of times, where they are using short-acting opioids instead of long-acting, and they are not coordinating with the other physicians, so that there may be multiple physicians prescribing medications for the same person, and they are unaware that they are all giving these medications.

So we need more of the educational side towards the physician and coordination and an individual, patient-centered model—what is your problem, finding out what they are treating the person for.

Senator SCHUMER. Right. My time is up.

Senator ROCKFELLER. But just barely.

Senator SCHUMER. I have a few more questions.

Senator ROCKFELLER. Go ahead.

Senator SCHUMER. All right.

The next question I have is, we have a database in New York where you are supposed to be able to log in, the physician is, to make sure that there are not people getting multiple prescriptions in multiple places. Some might do that benignly if you will, trying to relieve their pain; others might do it because they want to sell the drugs.

So my two questions are—but our doctors complain about our database being incomplete, and it takes too long. You cannot wait 20 minutes for the database to come back while you have a busy practice and you are watching the clock, as Dr. Cahana said.

So this bill would help to make the database better. I am interested in the databases that exist—I think there are 20 some-odd States that have them—do they work better, would this bill help them work better? I will ask one other question rolled into this.

How much of the abuse—when we have a high school kid in New York buying these drugs in the schoolyard, or addicted to these drugs, let us say—let us make it that. How much of that comes from just taking the pills out of his parents'—that were legally prescribed and needed—out of the parents' medicine cabinet? How much is from the drugs being stolen or in pharmacies, on trucks? They rob the trucks that carry the drugs and put them into the black market in a similar way that an illegal drug would be used. So that is a lot of questions, but all in the same sort of area. Who would like to respond? Dr. Coben?

Dr. COBEN. With regard to the prescription drug monitoring programs, I think it is fair to say that, since they are all State-based, there is quite a bit of variation, and variability in the quality and the issues in using all of them. I know that there are difficulties that relate to the frequency and rapidity with which the information gets into the database. So, for example, it may be up to 2 weeks in a State before the pharmacy actually reports a prescription.

During that time, lots of prescriptions can be filled. There are issues with regards to accessing the data and the timeliness of accessing the data from the provider side, from the physician side. One of the biggest challenges that I have dealt with in my practice is finding a unique identifier for each individual whom I see.

Senator SCHUMER. Sure.

Dr. COBEN. The same last name, same first initial, can get recorded lots of different ways in a particular database. So I think efforts to improve and standardize these, and also to share the data across State lines, are vitally important and can really be very helpful. Also, not only would this be helpful in curbing abuse and doctor shopping, but also helpful in reducing physicians' withholding medications from people who really need them, because many of us have suspected drug-seeking when in fact, when we go to the database, we find that it is not drug-seeking. So, I think it could be very helpful. I think if the bill can address that issue, it would be extremely beneficial.

On your second question regarding where the medications are obtained, we know from at least self-reported data that teens report they are obtaining prescription drugs from family members and friends, and from the medicine cabinets. Now, where those are coming from, and exactly the friends, and where they are getting them from, I think is still unclear.

Senator SCHUMER. Any others?

Dr. CAHANA. So, in regard to that question, a survey that was done in the State of Washington put the number at 57 percent of teens, in our last youth survey, who said that they took prescription drugs from their family medicine cabinet, and 10 percent of our 10th graders said that they have tried prescription drugs at least once, for recreational use, at something that they call a pharm party. So that is the first question.

The second is, we added——

Senator SCHUMER. Just to sort of—but sometimes they will start with the drugs in the medicine cabinet and then they get so addicted, they need to go on. Is that 57 percent where they started with prescription drugs or is it teens who generally use them? You are talking, with these pharm parties, I take it, occasional use and not real addiction?

Dr. CAHANA. Well, they said that the first source——

Senator SCHUMER. First source. Got it. That was my question. Thank you.

Dr. CAHANA. And there is a parallel increase in prescription drug abuse and heroin abuse, as well as referrals to treatment centers. It is parallel because it is very expensive to maintain a prescription drug abuse habit.

The second thing is—I agree with my colleague—the technological limitations that we have on the usefulness of prescription monitoring programs. What we have done very specifically in the State of Washington is develop a program called EDIEP, the Emergency Department Information Exchange Program, where all our EDs have better penetration in the eastern part than in the western part of the State where they are networked, so if someone walks in, then the name is flagged.

It is not so much as withholding, as Dr. Coben spoke about, but really contacting, through a call center, the primary care doctor to say, did you know that Mr. Smith has visited, in the last 24 hours, three emergency rooms on the I–5 corridor, and, if the patient does not have a primary care provider, to assign them one, because that is the whole idea, taking this vulnerable population and assigning them to some primary care. So it is not so much the policing, but identifying and using that as an opportunity to improve their care.

Senator SCHUMER. Anyone else? Dr. Schwab?

Dr. SCHWAB. Yes. In the Medicare population under Part D, and in our program, one of the ways you identify this is through early refill identification. With the early refill, you do not know why that early refill is. It could be someone who is themselves abusing more drugs, but it could also be someone in the family stealing that out of the medicine cabinet.

Just identifying the early refill does not solve the problem. You then have to contact both the primary care physician and the member themselves and ask them, do you have more pain or more need

now or is it that someone has stolen the medication, and doing a referral that way.

Senator SCHUMER. Thank you.

Thank you, Mr. Chairman. That was great.

Senator ROCKFELLER. Thank you, Dr. Schumer. [Laughter.]

This question is to any or all of you. There is a lack of geriatricians—I am just trying to make a comparison here—in this country. There is not a lack of geriatricians being trained in medical schools, but they get out, and they start to practice, and they find out that other specialties are doing far better than they are. They have children, and they just gravitate towards other specialties, and thus the geriatricians are not available to the people who need them.

This is sort of the way the world works. Now, what I am leading to, therefore, is the need for more knowledge and training about pain as a symptom, as a disease, as a reality, as a not-reality in medical school. Obviously, I have never been to medical school, and I know the horrors of the schedule and becoming a resident, and are you allowed to sleep now after 2 days or are you down to 1 day? I mean, it is just so hard. There is so much to learn, so much new technology.

The video conversations that you were talking about, or maybe you, Dr. Cahana, where people can just talk, from WVU, to anybody in West Virginia just because they have that capacity now because of the technology. But with doctors, how much time did you spend on pain? But not just pain as a disease, but pain as sort of a very special problem in our society? Do you get training in that?

Now, that may not be fair to ask you because I do not think any of you graduated within the last 2 or 3 years, but still it is a fair question. What are we teaching in medical schools and residencies about this subject? In West Virginia, some people go to residents rather than doctors because they feel they may be easier to get at. Can you help me with this subject?

Dr. CAHANA. The Institute of Medicine report dwelt on that issue quite a bit. In their recommendations, the paucity of undergraduate training in pain is very present. I think the national average is about 7 hours in 4 years, which is clearly not enough. So there needs to be a revision of the curricula to see how to insert pain training in the undergraduate arena.

At the University of Washington, in our School of Medicine, we have revised it up to 24 hours and created electives that are actually sought after by medical students who say, I cannot believe at the end of the rotating, that I missed this training. So medical students want to do this. In a recent survey that we completed on 261 medical students, they all ranked their knowledge in their 4th year, last year, as poor to fair prior to when we started this, and they also want to go and get this.

In terms of post-graduate training, I think we are looking at two different subpopulations. One is, how do we train the community? Most of pain management is done in the community and in emergency rooms, and I think that video mentoring and tele-health solutions are very powerful tools to help specialists reach out in the community and create, as I mentioned earlier, outliers to pain

champions and to help physicians and providers feel more comfortable in their prescription habits.

Then there is a whole discussion of the quality of training of specialists themselves. It has been recognized that not all training programs emphasize a multi-disciplinary approach, and they are more geared into the technical or technological aspects of pain management. So there is both undergraduate and post-graduate education to the community and to specialty care that needs to be addressed, and I want to thank the committee for highlighting this.

Senator ROCKFELLER. It is interesting. Mr. Millwee, you join in this, too. I was actually surprised, and I forget which one of you said it, that after 6 weeks you are addicted for life. You said that, did you not? That is opioids. It is hard for me to actually believe that. I mean, I do because you say it. But if patients believe they could get away from addiction, that there would be sort of booklets out in the community, and what do you do, or do your doctors sort of gradually reduce medication, or whatever——

But if you just feel that you have been doing this for 6 weeks because you have certainly had pain for 6 weeks, then sort of you are in a hopeless land, and you just go ahead because you can get them, unless somebody says no. But what about this problem of getting off of the addiction? Because I would think that would be a source of great hope for opiod-addicted people as they look at their futures, even if it would not be applicable right away, because they were still suffering from that pain. But then how do they know if they are suffering if they are using the opioids?

Dr. CAHANA. What we found in that study that included two cohorts of patients, one Medicare and Medicaid patients and the other private paying patients, was that, if you are over 90 days on chronic opioids, the chance of you being on them 5 years from that date is over 50 percent. So that is what we found.

Senator ROCKFELLER. I accept that. But I am trying——

Dr. CAHANA. That physician needs to convey to the patient that they are committing them to this. Now, in the context of perioperative pain or after surgery or trauma, there is a healing process where, of course, opioids and the use of powerful pain relievers is appropriate and necessary and warranted. This is the transition I mentioned of pain as a symptom when there is an ongoing disease, and pain when it becomes the disease within itself.

Now, there is nothing wrong with being on chronic medications. There are multiple chronic diseases that necessitate taking a pill. It is the destructive behavior, it is the lack of functional recovery, and it is a burden that is associated with that that is troublesome.

So we do not focus so much on the pain, but we focus on the wellness, and the well-being, and that is what the dialogue needs to be with patients. It is not about negotiating, do I think I need a pill, yes or no? It is, let us understand, what are the functional goals, what do you want to achieve, and how do we reach that? It cannot be only by using pills.

Senator ROCKFELLER. Please?

Mr. MILLWEE. We considered that very issue in 2009–2010 and decided to add a Medicaid benefit, after discussion with physicians, for substance abuse treatment, because the problem many times

might be that the physician finds that, but there is no resource to refer a Medicaid client to get help.

So we added a substance abuse treatment program, so now you have a referral. So, if you do wind up in this chronic condition, you have had chronic pain and now you have some addiction to pain drugs, there is a treatment alternative as well.

Senator ROCKFELLER. Please?

Dr. COBEN. The other area that I think Medicaid and Medicare, in particular, can be very helpful in this regard, is by promoting the use of electronic health technology whereby one can then easily identify when they are reaching that threshold.

If electronic health records are in place in the physician's office, then that threshold that is approaching, the 90 days or the 6 weeks or beyond, can be flagged so the physician is reminded and can start to intervene, wean patients, or refer them to substance abuse treatment.

Senator ROCKFELLER. Please?

Dr. SCHWAB. Yes. I would like to tie in to your previous question of lack of geriatricians. For the older population there is the added complication, not of just the pain medication treatment, but the issue that they probably have multiple other co-morbid conditions and other medications that cause drug-drug interactions and other side effects.

In our lifetime, we probably will never see enough geriatricians trained to take care of this population and to be able to recognize how to manage all these medications. So it is going to take a whole team, whether it is the geriatrician helping support some primary care physicians, whether it is a continuing medical education, programs like we and other people do to train primary care physicians how to recognize and deal with multiple co-morbid conditions, and the treatment, and also the ancillary personnel, geriatric pharmacists, the case managers, that whole team working together with the individual.

Senator ROCKFELLER. I know in West Virginia there is one area where a group of doctors have just sort of had it with this problem and want to do something about this problem. They are not all doctors. You get social workers, you get a group, a team which works with a patient.

Now, I say that and feel very good about it. Then I say that and I also feel like the world does not work like that. There is not enough time in a doctor's schedule, in a hospital schedule, or in anybody's schedule, so that people can coalesce over a patient. But it seems to me that, in life, when people have serious addictions or serious problems, a team concept, a group working with them, frees up people to be more helpful as a concept. You would probably agree with the concept, but do you think that it is not realistic? Please? Now, you have ECHO, do you not? Is that Robert Wood Johnson?

Dr. CAHANA. Yes.

Senator ROCKFELLER. I meant to see them at 12:30, but we have seven votes, so it is going to be a little hard. They are good, are they not?

Dr. CAHANA. Yes.

Senator ROCKFELLER. Anyway, who would like to answer the question?

Dr. SCHWAB. I agree with the team concept. I think we need to get away from the idea that the team has to always be in the room all together at the same time.

Senator ROCKFELLER. All together.

Dr. SCHWAB. So the team can provide input in multiple ways either through other electronic communications, which are so available now, even things like video teleconferencing, so the team member could be at the university, and the rest of the team out in the field.

So, I think that is the way. It reduces the need for the physician to spend all that time and gets some of the support of other people, as you say, social workers, pharmacists, individuals like that.

Senator ROCKFELLER. What role can nurses play in all of this? Just talk.

Dr. CAHANA. A central role. We found out that, by hiring nurses as care managers coordinating the care, they become the gravitas around everybody, around the coordination. The coordination means not only to make sure that patients follow up on whatever the multi-disciplinary team comes up with, but also to prepare the patients, follow up, and monitor adherence.

So, having access to that information is important, and actually reaching out to the patient, educating the patient in real time, discussing findings, discussing a urine drug test, and if there are unexpected findings, how to do this, how to encourage the patient to understand that this is not a forensic test, but this is part of monitoring adherence and making sure that they are doing well, using every opportunity of surprise to be an opportunity of education and showing the intent to have patients be better and well.

Senator ROCKFELLER. Dr. Coben, before I go to you, is electronic data, just data information, is that available at every nurse's station? Is that available in every ward, or is that only available in doctors' offices? Are we using that to the extent that we can so people can find out who is taking what?

Dr. CAHANA. So I would say that currently this is a system that is growing, and that our coordinating nurse that is working as a hub between the pain center and the neighborhood clinics has that access, and nurses in the neighborhood clinics also have access.

So we can engage in what we call panel management, where we actually say, oh, I see Mr. Smith actually is not doing well. He was not supposed to come to the clinic. But because we are able to find that they are not doing well, we can call up either the patient or the nurse and find out what is going on.

The key, of course, is to make sure that we have these measurements in place and incent the behavior of assessing it. It is almost like a hemoglobin A1C for diabetes. You have to measure that in order to say that the patient is doing better.

So I would urge us to add that element of measuring. Without measuring, we cannot determine value, and then there is nothing to coordinate. Obviously there are administrative tasks to coordinate, but, in terms of patient well-being, we have to rely on the surrogate measurements that the patients report to us and on biological specimens like urine drug tests.

Senator ROCKFELLER. All right. Thank you.

Dr. Coben?

Dr. COBEN. I was just going to reiterate, in my comments earlier I had mentioned the patient-centered medical home approach, and I know that Mr. Millwee also commented on that as well. I think that that really does talk to the essential role of an extended care team so that the physician is not necessarily the one that spends all the time doing the assessments, and even the interventions.

Of course, the patient-centered medical home model is not just a model of care, but it is also a model of financing that care, obviously relevant to the committee. So I think that promoting its use can really help in terms of removing this fragmented care model of delivery that is really contributing to part of the problem, and engaging other extended care providers like nurses and mid-level providers in the care of the patient.

Senator ROCKEFELLER. Physicians' assistants?

Dr. COBEN. Yes. Absolutely.

Senator ROCKEFELLER. I can remember, in West Virginia we were one of the first that had a school for physicians' assistants. There was a lot of laughing going on. Well, there is no laughing going on anymore. Dr. Cahana, I loved it when you described—because you were so honest about it—being in an appointment and you are late getting there, the patient is late getting there.

I mean, everything has to work perfectly for you to have the time that you need, and nothing ever does work perfectly, so that you are reduced to getting the basic information and making a basic decision, knowing that you are not doing all that you can do or that you should be doing, but there is nothing you can do about that.

So, I mean, it does argue for having other people share your burden with you. So having said that, how would you recommend—let us say, Medicare and Medicaid, the older, fragile population where it seems to me it would be much harder for a doctor to say, no, you should not be taking that pain medication, because that is a very different psychology.

If you feel that you only have a few years to live, or you have so many illnesses built up inside of you that having a pain medication is like eating, every day you just have to do it, and therefore it puts a great burden on a doctor. How would you suggest, each of you, that we best approach this problem in Medicare and Medicaid?

Mr. MILLWEE. In Texas, we found care coordination is really what works. When you look at your population, about 70 percent of the people in Medicaid generally just need some basic primary care. About 30 percent have chronic health care conditions that really benefit from care coordination.

So we have created a model, we call it Star Plus, where we have that care coordinator who is working on, not just the acute care needs, but also long-term care needs, and is very much attuned with that client in understanding if there is a deterioration in their condition. They have that time to spend with them that maybe the physician does not have, and around that person you are building that primary patient-centered medical home. We include our dual-eligibles in that population.

Even though we are not responsible for the acute care piece of that, we help manage that as well and coordinate on the Medicare side. So it really comes down to targeting the population that really can benefit from that care coordination. When you look at it, it is a small subset that really drives cost and has the potential for prescription drug abuse, we believe.

Senator ROCKEFELLER. Thank you.

Dr. CAHANA. I want to thank you for this opportunity really to share, how did we come up with these solutions. The system is, as Dr. Coben mentioned, fragmented, inconsistent, and the cost is unsustainable. So the strategies that we brought to the table are just to address those. So for the fragmentation, we are talking about coordination. For the inconsistency, we talk about the education. Education can be done in many ways, but the video mentoring and the ECHO project are very exciting.

The unsustainability of things that lack value can only come out by measurement. If I measure, then I can know if that thing helps or not, and to whom. So I would submit to the committee that if you would help us, encourage us, and incent us to measure as standard of care—that is the measurement-based care part—that me looking at patient-reported outcomes of patients telling me about their pain, their mood, their function, looking at their urine or any other biological fluid, and looking at things that are either expected or not expected, at a frequency that has been determined in the literature as standard of care, and to be paid for that, that is, for me, the most important thing.

The second most important thing is to pay for video mentoring, or to encourage us to use and subscribe to the video mentoring, which by the way, we do during lunchtime because we do not want to interrupt the work flow. So for the University of Washington, and the Specialty Services, we do it very early in the morning before we start our day. For the community, we do it during lunchtime. That is not a desired situation.

It has to be part of our practice where we know that we have our daily, or bi-weekly dial-ins, where we talk to the specialists and we present patients, and we can follow up on how they are doing, and you have that multiplier effect of saying, oh, so this is how you treat a patient who is elderly and has these co-morbidities, et cetera.

So those two things, in addition to what was submitted in 507 of the training, the education, the clinical guidelines, and the prescription monitoring program support, encouraging us to measure, incenting us, paying us to measure, and paying us to do the video mentoring.

Senator ROCKEFELLER. Thank you.

Dr. Schwab?

Dr. SCHWAB. Well, for nearly 30 years we have known that care coordination in the Medicare population works to do this. But it is not just simply care coordination. You really need to target the people whom you provide that care coordination to. To do the targeting, you need data. The data comes from both Medicare sources and from the individual themselves, and then you put together a team that has shared responsibilities for managing and making sure that that person is identified and gets their needs met.

In addition, data that I do not think we do a very good job now of coordinating is entire data. There are promising things, like the Health Information Exchanges, where data coming in from all sources—like right now in the Medicare population we have no data from the Veterans Administration for people who share those two services. We know there are some, a small amount.

Senator ROCKFELLER. But how can that be? I mean, they are the ones who are really good at having data. DoD is terrible at it, but the Veterans Administration——

Dr. SCHWAB. The Veterans Administration is great at having data.

Senator ROCKEFELLER. But they will not share it?

Dr. SCHWAB. If they go out to the private community, there is no information from the private community to the veterans, or vice versa, from the veterans to the private community. Small numbers, but there is no communication there, and through other programs, too.

If someone just buys drugs on their own with their own money, that communication is not provided to either a health plan or to the Veterans Administration. In a Health Information Exchange that really works well, all pharmacy information would be in one database and everyone would share that information.

Senator ROCKEFELLER. Well, that is very helpful. That is very helpful. Thank you.

Dr. Coben?

Dr. COBEN. The only thing that I would add to the earlier comments is, I think the critically important role for screening is brief interventions and referral to treatment for patients with substance abuse. We know from a variety of research projects that have been implemented across the country that screening and intervention programs work, they are cost-effective, but they have not really been sustainable.

Part of the reason that they are not sustainable is because insurers are not paying for the time that it takes to screen and refer and do these brief interventions. So, I think putting that into the armamentarium, if you will, for Medicare and Medicaid programs could be quite helpful.

Senator ROCKEFELLER. Let me ask another question. It is nice being all by myself here. [Laughter.]

This is controversial, but not to me. I was responsible for getting it going, the Independent Payment Advisory Board, or IPAB. It has to do with reimbursements for physicians for durable medical equipment, DME, and for hospitals, and for all the rest of it. Several of you have mentioned measuring outcomes as a way of proceeding on what we have been talking about.

Well, that is what the Independent Payment Advisory Board is all about, is measuring outcomes. In other words, if rural hospitals have bathrooms that are not clean, then all of a sudden MRSA emerges and spreads.

You asked about having incentives. Well, there are positive incentives and there are negative incentives. A positive incentive comes out of IPAB because it says that, if your outcome of what you are doing—and this is not just prescription drugs we are talking about, but in general, a philosophy of how you carry on medi-

cine—that if we have a system of lobbyists and then practitioners, then I will just be very honest with you, I speak a lot when the American Medical Association, the American Hospital Association comes to town.

They take up the entire Washington Hilton, the largest ballroom in town, thousands and thousands of people. You look at the program, and often I am asked to speak, and then some Republican is asked to speak. Then you look at the program and the schedule is that everybody then goes to the Hill and visits all their Senators and Congressmen so that they can get more payment for here or there, a lot of which is all legitimate.

With durable medical equipment, it may be, it may not be. With hospitals, it may be, it may not be. But, if you take that out of the hands of lawmakers, can you not agree that lawmakers are the worst possible group of people to determine how you should be reimbursed, because that is what is happening now.

It works because, if you have the right lobbyists, often they have been people who have sat on this committee or some other and know about health care, and they go work on—I just turned down a lobbyist who served on this committee who wanted to come talk with me, and I am not going to see him because I just do not like that.

I do not like that way of doing business. I think you ought to reimburse based upon outcomes and improvement compared to previous years, all the measurements that we have been talking about, people having cleaner hospitals, better hospitals, more coordinated care. All kinds of things that get encouraged by the incentivization of better reimbursement should be decided by 15 people—this is where people go crazy, until you mention, well, people like Gail Wilensky or Stuart Altman, and then they say, oh, well, I can trust them.

This would be the next generation of Gail Wilenskys and Stuart Altmans, but there are people, and there are thousands of them in this country, who are really good on health care policy, and really good on reimbursement issues, and who have no axe to grind, cannot be pushed around by lobbyists. They end up making the decisions, which the Congress can only override by a two-thirds vote, of how people should be reimbursed each and every year.

Now, that obviously is very complex. It has to be done fairly. Mistakes would be made at the beginning. But it seems to me getting away from Congress—and this is not sort of a right-wing thing I am talking about here, getting Congress out of your lives, but in this case I think you would do a lot better with Congress out of your lives with respect to reimbursement and incentivization for doing what you all seem to want to do anyway but cannot get done.

Now, is that a program which horrifies you, which you have no particular opinions on, or you think is a good idea, or what? And just be honest with me. Look, I have free time here.

Dr. COBEN. Sounds good to me.

Dr. CAHANA. So we always strive to do educated policies that are based on evidence, and the quality of the decision really depends on the quality of the data, on the information that you use to make that decision, unless you decide that you want to ignore that.

Traditionally, health technology assessment committees, or any type of committees that can be on a State or Federal level, or in any health system, are based on what we would call evidence-based medicine which relies on efficacy data, which basically means that these are studies that are done in sterile conditions. These are studies that are done not at the University of Washington or not where you practice. So there is a limitation on the generalizability of those studies.

The idea of inserting measurement at every clinical encounter in your clinic is called effectiveness, not efficacy. Hence, the comparative effectiveness research that basically shows me, so my program is a large program, has a trauma hospital, Harbor View Medical Center, has the University of Washington Medical Center, has Children's, has the VA Puget Sound Health Care System.

The results of the quality from treatments from opioids or epidurals or any other treatments are very different from site to site. So, without the ability to say what is the progress of our patients, it is very difficult to give an idea of what is the right thing to do.

So again, in my disclosures, I always say I do not like opioids, I do not hate opioids; I do not like epidurals, I do not hate epidurals; and I am agnostic to integrative medicine. Just show me that it works. When I asked my providers before we had the system, how are your patients doing, they would say fine. I would say, how do you know? Because there are no complaints.

The only feedback that we had at that time was if someone would knock on your door and say that one of your patients died from an overdose. That is too late. So I lead from the assumption that each and every provider in my large division wants patients to get better and would feel very uncomfortable if they would get a report card, either on each patient, or at the end of the month, that says these are the type of patients that you are not improving.

So it is key, and it is unfortunately missing in many of the strategic plans of the large stakeholders, in the DoD–VA task force, in the Office of National Drug Control Policy strategies, even in the Institute of Medicine report. I do not think that the idea of measurement is explicit enough to allow policymakers to say, this simply has to be practiced, like in any other thing in medicine. We measure hemoglobin A1C for sugar, we measure blood pressure for hypertension. I do not ask someone, are you thirsty and they say, yes, and determine the dose of insulin according to that.

I want to know pain, pain interference, mood, function, physical function. What do you want to achieve, and how are we going to get that? That transforms the way patients think about pain. It transforms the way we, as providers, think about it, so it improves the dialogue, and it also improves our ability to aggregate these reports and make decisions.

Senator ROCKEFELLER. Well, you are an extraordinary, thoughtful group, and very direct. So how is your morale as you go to work every day? This is a serious question. Do you jump out of bed and say, I cannot wait to get to work, or is the burden of practicing medicine in America these days—I mean, medical schools are filled with people. It used to be that we were losing doctors in West Virginia, now we are gaining doctors. They want to come.

A lot of people want to go and practice rural medicine, maybe much more so than some years ago. The new health care bill, which everybody loves to hate but I do not, has I think $10 billion for rural health clinics, new ones, which can take advantage of all this mentoring over media. I mean, it is all very exciting to me. So, that was a rather awkward question on my part, but I am interested. Please?

Dr. SCHWAB. Some days the morale is very low when you look at all the challenges, all the things that you cannot accomplish. However—and I wish I would have brought it with me—I just today received a letter from one of our members, an 83-year-old gentleman who said, I cannot thank you enough for what you have done for me and my wife. I would not be here today if you had not done—and he went on to describe how his medications were changed and he was now able to be more cognizant and take care of his disabled wife. It is a letter like that that says this is all really worth it.

Senator ROCKFELLER. Well, it is like the example I gave in my opening statement.

Dr. SCHWAB. Very similar.

Senator ROCKFELLER. Yes. Yes, that is great.

Please?

Dr. COBEN. Senator, I am on the front lines in the emergency department. I enjoy what I do, and it is a privilege to serve the State of West Virginia and other places that I have worked throughout the country. I think there is great hope, great promise for some of the new technologies that are rolling out in health care.

I think the parts that frustrate many of us are what I alluded to earlier: the fragmentation in care, the inability for patients to have primary care providers and gain access to those providers. That is not just in rural communities, that is everywhere.

Gaining access to the physician in a timely manner, so that patients who come to the emergency department, who truly have emergencies and need emergent conditions addressed, that is the part that frustrates us. Of course, there are also the other business aspects of the chart-keeping and record-keeping, et cetera, et cetera. But the practice of medicine, I think, is exciting and still stimulating and invigorating.

Senator ROCKFELLER. Well, is the computer helping you on the paper frustration part?

Dr. COBEN. No.

Senator ROCKFELLER. No? All right.

Dr. COBEN. I think that it certainly has its benefits and has great potential. It is still yet to be realized, I think, in many places. But it has not diminished the time that we have to put into the record-keeping part of what we do.

Senator ROCKFELLER. Any other comments? Then I promise to leave you alone.

Dr. CAHANA. Sir, I feel very fortunate, as chief of the Division of Pain Medicine at the University of Washington, which is the birthplace of modern pain medicine—the first pain clinic in the world was actually there——

Senator ROCKFELLER. I did not know that.

Dr. CAHANA. And it is very appropriate that the thoughtful leaders that we have there are trying to use this epidemic, and true challenge, and turn it into an opportunity to reflect better about pain, suffering, and health care and health care delivery.

So I do share Dr. Schwab's sentiment that one day we will laugh about this, it just simply will not be today. But this is a great opportunity, and I would not want to be anywhere else but in this place. Thank you, sir.

Senator ROCKFELLER. Terrific. Thank you.

Mr. MILLWEE. Well, I add to that enthusiasm. Now is the best time in the world, in my mind, to be a Medicaid director. There are so many things that are happening, and it is exciting being on the forefront of that and laying the groundwork for some things that will probably come to fruition in 2015 and 2016 around how we are going to move this program from basically a transactional kind of payment process to really transformational.

We are looking at improving quality, addressing potential preventable events, laying the groundwork for electronic medical records. We are building a great future right now. Sure, it is a lot of work, but it certainly is gratifying.

Senator ROCKFELLER. Great. Well, I totally thank you all for coming. Hearings are important because often they are carried on C–SPAN. People learn from them, we learn from them. We cannot do this on our own. We need you to guide us and help us. The fact that you have been so honest has been very, very helpful to this hearing. So, I thank you for your cooperation. Whatever you are going to do for the rest of the day, I hope it is as helpful as this morning.

The hearing is adjourned.

[Whereupon, at 11:50 a.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

UW Medicine
DIVISION OF
PAIN MEDICINE

Introduction

Chairman Rockefeller, Ranking Member Grassley and members of the subcommittee, I would like to thank this committee for inviting me to discuss the clinical aspects of good pain management and more importantly tell you about the applied solutions we have put in place at the University of Washington (UW) and in the State of WA. I am pleased to report the very promising preliminary results of these interventions, especially in the Medicare, Medicaid population.

There is virtually no evidence to support that high dose opioids relieve pain or improve function, or is safe.

It is unfortunate that in the English language we use the same word for pain as a symptom and Pain as a disease. Pain as a symptom is a by-product of a disease. Take care of the disease and the pain goes away. However when pain becomes the disease, when there is nothing broken to fix, infection to cure or to tumor to operate upon, treating pain as a symptom doesn't work. It actually makes things worse.

This is why we are seeing so much harm with prescription pain drugs.

There is growing evidence that shows that opioid treatment over 90 days is usually a commitment for life.

To treat pain as a disease, a treatment plan may *sometimes* include opioids, but *always* includes listening to the patient, determining what is interfering with his or her life, define functional goals and individually tailor a variety of medical, exercise, mind-body treatments and healthy life choices.

A large volume of material has been recently published in the GAO, IOM, ONDCP and DoD/VA Pain Task Force reports, and there are a few points worth remembering. First there is virtually no evidence that high dose opioids relieve pain or improve function in chronic non-cancer pain. Second, there is growing evidence that shows that opioid treatment over 90 days is usually a commitment for life. Third, it is usually the most vulnerable, sickest and disadvantaged patients (Medicare, Medicaid, Veterans) who receive the most opioids, oftentimes because that is what their healthcare professional knows and what the insurance will cover (Bradley et al, 2011; Seal et al, 2012).

Opioid related death crisis is in essence a 'reimbursement crisis', since medications are the best reimbursed pain treatment in the safety net population.

Opioids are potent and reliable pain relievers, but they are not panacea. They do not work for all pain, or for all patients. There are no 'good' or 'bad' opioids. There are only opioids that are prescribed appropriately, safely or not. Although the challenges of balancing benefits and harm of opioids exist, they are not different then other treatments in medical practice. Responsible opioid prescribing relies on subtle changes in attitude, relatively simple changes to policy and a willingness to examine one's approach to opioids. (Scott Fishman: 'Responsible Opioid Prescribing', Federation of State Medical Boards, 2nd edition, 2012, Waterford Life Sciences).

University of Washington (UW) and WA State efforts to prevent prescription opioid-related deaths include:

Measuring pain, mood and function at each clinical encounter is key to understand patients and the effectiveness of treatments

1. Since November 2008, the UW Pain center has been using a patient screening and assessment tool during **every** clinical encounter. This tool allows patients to describe how pain impacts key domains of their lives, including pain interference to essential activities, status of physical functioning, emotional well-being, satisfaction, and potential risk for prescription opioid abuse and misuse. Combined with routine urine drug tests (Laffer, 2011) this model of measurement-based care informs clinicians about important patient characteristics, treatment progress, and the overall the patients visit (Cahana, 2011). It also permits decision makers to identify exceptional outcomes, efficiencies, and needed resources for expansion of services to provide effective and efficient outcomes.

Urine drug testing is necessary for assessing the risk of opioid therapy and monitoring patient's adherence to treatment

Opioid related deaths have decreased up to 65% in counties using video-mentoring technology (ECHO)

2. In order to increase the availability of specialty care we initiated twice a week a 90-minute TelePain provider-to-provider consultation. This service called **ECHO** (Extension for Community health Outcomes), was developed in the University of New Mexico and is designed to improve access to specialty care for underserved populations with complex health problems. It uses video-conferencing technology to train primary care providers to treat complex diseases, and has been shown to be as effective and safe as specialty care (Arora et al, 2011).

Since March 2011 we have given 2240 training hours to 1500 health professionals from 76 locations, with an average of 40 providers dialing in at each session. We have documented an improved sense of knowledge of opioid prescribing among our primary care providers treating patients with chronic pain and an even higher decrease in mortality rate in counties receiving education (up to 65%) compared to the state average (35%) (Merril, under revision).

Tapering patients through a second opinion opioid review consultation improves patient outcome and is cost effective

3. Since 2010 we provide a second opinion consultation for Medicare/Medicaid beneficiaries receiving high doses (over 1000 mg MED) of opioids, following the model of the second-opinion consultation developed for children treated with antipsychotics, which was shown to improve patient outcome and cost-effective (Thompson, 2009).

Most pain patients are seen by primary care providers or in the emergency room

4. Look over the expert shoulder (LOES) is a postgraduate educational program, allowing advanced training and certification in pain community practice settings. LOES-trained "Pain Champions" are expected to serve as educators, leaders, and resources in communities where specialty pain clinics are unavailable or inconvenient due to excessive distance.

Targeted education for Top prescribers engages providers to become 'Pain Champions'

Emergency Department Information Exchange Program has decreased unnecessary ED visits by 56%

5. Also in use is an Emergency Department Information Exchange reduces the chance of patients obtaining multiple prescriptions from more than one provider. Providers have access to information on previous visits and prescriptions and this decreases the possibility for patients to obtain non-prescribed opioids that may be misused or abused. For patients denied an unscheduled prescription refill request at the emergency department (ED), EDIE facilitates communication between the ED and patients' primary care provider (PCP), alerting the PCP to make a decision on subsequent interventions that may be warranted. In the Spokane area the use of EDIE has decreased unnecessary Emergency room visits by 56%.

The Medicaid 'Lock in' program with a single provider, single ED, single hospital program has improved patient safety

6. Since 2012 a Prescription Monitoring Program (**PMP**) has been in place at UW and we are currently establishing an on-line, real-time controlled substance reporting system to track the prescription and dispensing of controlled substances. This requires practitioners to review a patient's prescription history on the system *prior* to prescribing and require reporting the prescription *at the time* of issuance. It also requires pharmacists to review the system to confirm the person presenting such a prescription possesses a legitimate prescription *prior* to dispensing and requires pharmacists to report dispensation of such prescriptions *at the time* the drug is dispensed.

"I never knew these pain patients were so nice and so grateful and I can't believe I nearly missed this course"...

4th year medical student after a course in Pain Medicine

AHRQ and CDC have endorsed the AMDG guidelines

7. State Guidelines:

In response to the emerging epidemic of deaths from prescription opioids reported from Washington State (WA) (Franklin et al., 2005) and nationally (Paulozzi et al., 2006), the Agency Medical Director's Group (AMDG), representing all of the WA public payers (Medicaid, workers' compensation, corrections, health, public employees), convened in 2006 an advisory group of clinical and academic pain experts. The group developed an Interagency Guideline on Opioid Dosing, which was then implemented as a web-based educational pilot in April 2007. The hallmark of this Guideline, in addition to widely agreed-upon best practices, was the inclusion of a "yellow-flag" warning opioid dose threshold of 120 mg/day morphine-equivalent dose (MED).

The risks of dying from opioids increases 9 fold at doses over 120 mg morphine equivalent a day.

The Guideline recommended that prescribing providers obtain consultation from a pain medicine expert for patients with chronic non-cancer pain (CNCP) receiving opioid doses greater than 120 mg/day MED, whose pain and function had not substantially improved during opioid treatment, before continuing to prescribe daily doses above 120 mg MED. This threshold is based on epidemiological data showing a significant relationship between opioid-related morbidity and mortality (Braden et al., 2010; Dunn et al., 2010; Bohnert et al., 2011; Gomes et al., 2011).

Implementation of AMDG guidelines have resulted in 50% and 35% decrease in deaths from opioids between 2009-2010 in the Worker's compensation and Medicare/ Medicaid beneficiaries

The dosing guidance in the WA Guideline was specifically directed to address the probable mortality risks of chronic high-dose opioid therapy that was not providing clear benefit and included a web-based opioid dosing calculator that physicians could use to quickly to calculate the total daily MED from all opioid medications.

Since initial implementation of the AMDG guideline, we report 50% and 35% decreases in opioid mortality in the WA workers' compensation population and the Medicare/Medicaid population respectively.

Summary

Over-reliance on opioids (but also diagnotic tests, procedures and surgery) is poor pain management. It is a result of a combination of:

1. **Insufficient** provider training and patient education
2. Lack of accessible real-time **patient reported outcome data** for the prescriber, to indicate whether prescriptions or other treatments are effective and safe
3. Presence of strong financial incentives to **over-prescribe**, over-test and over 'proceduralize' pain complaints, especially in the Medicare and Medicaid population.

A comprehensive strategy to decrease opioid-related deaths should include:

1. Best clinical practice guidelines

2. Prescription Monitoring, Take Back and Emergency Department Information Exchange Programs

3. Tele-Health and video-mentoring solutions to improve access to specialty care

4. Incent providers to assess, coordinate care and measure pain, mood and function at every clinical encounter

For better health, better health care and reduced costs I suggest:

1. **Incent** providers that follow best practice guidelines, spend time to assess patients, coordinate care and **measure** pain, mood and function at every clinical encounter
2. **Pay** for video-mentoring (ECHO), behavioral counseling, integrative medicine and **decrease payments** to treatments of low or unproven value (such as repeat tests, high dose opioids, repeat procedures and surgery).
3. Fund prescription monitoring programs, Take Back programs and Emergency Department Information Exchange programs
4. Fund undergraduate and postgraduate **training** that will improve competence in pain medicine both for primary care and for specialists (Dubois, 2010)

The ultimate answer to lethal and expensive pain treatments is to 'demedicalize' pain as much as possible. In general the more widespread the pain is, the less medically intensive the pain treatment should be.

(Sullivan, 2012)

Testimony of Jeffrey Coben, MD, Director of the West Virginia University Injury Control Research Center before the Senate Finance Committee/Subcommittee on Health Care, on Thursday March 22, 2012 at 10:00 a.m.

Chairman Rockefeller, Ranking Member Grassley, and distinguished Subcommittee members, thank you for inviting me to discuss this critically important public health issue. I would like to begin by providing you with some perspectives on the problem of prescription drug abuse from the viewpoint of a physician who has practiced emergency medicine in this country for nearly 25 years, and has spent the last 8 years working within West Virginia, a state that has been particularly hard hit by this growing problem.

As you know, emergency physicians are on the front lines of health care. We see, first-hand, the health and healthcare problems that are impacting our communities. The alarming increase in deaths, hospitalizations, and emergency department visits associated with drug overdoses over the past decade has been well documented. These statistics, which I will return to in a moment, tell an important story. But the numbers alone do not adequately describe the ravages of prescription drug misuse and abuse. I have seen the pain and torment of families who have suffered the loss of a family member; I've seen children removed from their homes; and I have seen shootings, stabbings, and suicide all as a direct consequence of prescription drug abuse.

As an emergency physician, I can also attest to the benefits of prescription opioid analgesics. The vast majority of patients we see in the emergency department are coming to us in pain, and when used appropriately, opioid analgesics can be some of our most effective treatments for painful conditions. Anyone here who has fractured a bone, suffered through a kidney stone, or undergone a painful surgical procedure can probably provide their own commentary on pain – and the relief they received from different medications. In fact, in many cases, providing adequate pain relief may be the best, only, or most important thing that we as healthcare providers can do for our patients. Fifteen years ago physicians in this country were being heavily criticized for not adequately addressing pain, and there were quality improvement initiatives designed to *increase* the use of opioid analgesics. Now, only a short time later, we are faced with a rising epidemic of prescription drug overdoses, fueled in part, by a dramatic increase in the prescribing and distribution of strong opioid painkillers.[1]

During the first decade in this century, we experienced a 128% increase in fatalities associated with poisonings and the majority of these were unintentional overdoses associated with prescription drugs.[2,3] In 2008, over 41,000 people died as a result of poisoning and nearly 90%

of these poisoning deaths are caused by drugs.[4] Prescription drugs abuse is the fastest growing drug problem in this country and prescription painkillers are involved in more than 40% of all drug poisoning deaths. There is no indication that this trend is leveling off.[5]

This is certainly a crisis that demands our attention. Balancing the appropriate and judicious use of prescription drugs with efforts to prevent their misuse and abuse is a complex and difficult challenge, and I applaud this Subcommittee's efforts to help address this challenge. While regulations and other approaches involving Medicare and Medicaid cannot solve this problem alone, they can certainly play an important role.

Although the prescription drug abuse problem can seem overwhelming, we should not lose sight of one of the most important public health success stories of our time. During that same first decade of this century in which we have noted the alarming rise in drug overdose deaths, there was a 25% reduction in injury fatalities due to motor vehicle crashes.[1] From the perspective of an injury control researcher, I would like to suggest that there are some important lessons we can learn from the strategies that have proven successful at reducing motor vehicle-related deaths.

Approximately 50 years ago, the United States was experiencing a dramatic escalation in deaths from motor vehicle trauma. We responded by developing a wide array of national, state, and local evidence-based interventions that are integrated, systematic, and sustained. We have improved the safety of our highways, demanded safer motor vehicles, and implemented public safety and education campaigns. These interventions combine engineering, education, economics, policy, legislation, regulations, enforcement, and enhanced trauma care systems.

As we now attempt to confront the problem of prescription drug abuse, a similar integrated strategy is needed. As with the motor vehicle trauma crisis of half a century ago, there are multiple factors contributing to the rise of prescription drug abuse. Addressing this problem will require a multi-factorial approach, and will require that we broaden and sustained our efforts over time.

Just as we have worked to change public attitudes towards seat belt use and drunk driving, we will need to address misinformed societal attitudes towards the recreational use of prescription opioids. The majority of teens responding to a national survey believed that using an opioid medication without a prescription did not pose a great health risk.[6]

We need to do a better job educating physicians and other healthcare providers about the safe and appropriate use of prescription analgesics and sedatives, including the broader use of recently developed expert pain management and opioid prescribing guidelines; and the best approach for screening, brief intervention, and referrals for patients with substance abuse problems. Within the last few years, new guidelines for prescribing opioid analgesics for chronic, non-cancer pain, have been developed by expert panels and disseminated, including the 2009 guidance jointly issued by the American Pain Society and the American Academy of Pain Medicine,[7] along with similar guidance issued by other expert panels in the U.S., Canada, and Great Britain.

Programs aimed at providing a combination of expert prescription guidance to providers, coupled with tailored educational programs, have been implemented in states or locales, and some have shown promise. An interim evaluation of one such program in Washington State found that the fatal overdose toll had leveled off after prescription guidance and prescriber education.[8] A program in the State of Utah combining prescription guidance and education resulted in a 14% reduction in overdose deaths the year following implementation.[9]

Efforts to improve, standardize, and facilitate the more widespread use of Prescription Drug Monitoring Programs (PDMPs) are also needed. PDMPs offer the potential that prescribers will one day have real-time access to their patients' prescription histories from monitoring systems in each state that are linked with those in other states. Thus, patients who seek to acquire prescriptions for these dangerous controlled substances from multiple doctors and multiple pharmacies may be identified before additional prescriptions are written and dispensed. These "doctor-shopping" patients can then be referred for treatment where necessary, and curtailed (and prosecuted) if they are found to be diverting these drugs for profit. Through the efforts of the U.S. Department of Justice Harold Rogers Prescription Drug Monitoring Program, and the efforts of organizations such as The Alliance of States with Prescription Monitoring Programs[10] and the National Alliance for Model State Drug Laws[11], the number of PDMPs in the U.S. has rapidly increased during the 2000s. Currently, there are operational programs in 40 states and 1 territory, and laws that authorize the implementation of PDMPs in 9 other states.[10]

Despite the presence of these programs in a large majority of states, the ideal national network of linked prescription monitoring systems is not yet a reality. Current systems are not all comprehensive, capable of providing real-time reports, nor linked for data sharing.

There is also, of course, a critically important role for law enforcement and the DEA in detecting, and intervening to block, illegal efforts to obtain and distribute prescription painkillers, whether by fraud or theft.

Focusing now more specifically on public insurance programs, there are several strategies that need to be considered and evaluated. These include the expanded use of:

- real-time analysis of insurer claims data to identify potential cases of doctor shopping and other forms of abuse/misuse
- Drug Utilization Reviews, particularly those that can be implemented at the Point-of-Sale
- single provider/single pharmacist "lock-in" programs for individuals who have been identified as abusers or at high risk of abuse

Medicare and Medicaid have also had an important role in promoting the use of health information technology, including electronic health records and electronic prescribing. These systems have great potential for not only reducing fraudulent prescriptions, but also for helping to identify high-risk patients and potentially dangerous combinations of prescription drugs. Efforts to promote and incentivize the meaningful use of health information technology will be of continued benefit, and should be sustained.

Similarly, several state Medicaid programs have been at the forefront of efforts to promote the use of the Patient-Centered Medical Home Model of primary care. If done effectively, this medical home model also has the potential to help address the problem of prescription drug abuse by promoting better care coordination, the use of an expanded care team to better assess and detect substance abuse problems, and helping to promote integrated care with treatment resources within the community.

We must also recognize the important role for substance abuse treatment and, in most states, the real and critical shortage of treatment service availability. While shortages are apparent today in treatment facilities and resources, treatment needs may trend upward in the future. The Centers for Disease Control and Prevention (CDC) has estimated that for every overdose death caused by prescription opioids, there may be 461 nonmedical users.[1] SAMHSA reports that 2 million people used prescription painkillers non-medically for the first time in 2010,[6] which suggests that during 2012, another 62,000 people will become dependent upon these drugs. If the number of users continues to grow at a similar rate, the number of prescription-opioid-dependent people in the United States (estimated 210,000 in 2012) could reach half a million by

2017. Providing beneficiaries with coverage for substance abuse treatment is another important role for the state Medicaid programs. The programs should also try to ensure the quality and availability of services for their beneficiaries.

Finally, as an injury researcher, I would be remiss if I didn't mention the possibility of future interventions that are directed towards the "agent" of this problem—the prescription drugs themselves. Just as we have made our automobiles safer, we can find ways to make these medications safer. Drug manufacturers are working on new pharmaceutical preparations that formulate opiates in such a way as to prevent their misuse. An abuse–deterrant form of oxycodone, for example, comes as a gelatin capsule that does not release the drug when the attempt is made to grind it into a powder for snorting or when abusers attempt to extract liquid from the capsule for injecting.[12] Manufacturers are also creating formulations from combinations of drugs that retain opioids' analgesic properties while simultaneously blocking their euphoric and addictive effects. One such new drug, which is currently available for prescription only in the United Kingdom, combines prolonged release oral oxycodone, an opioid agonist, and naloxone, an opioid antagonist.[12] Similarly, there are new devices being developed that are focusing on the dispensing of limited quantities of medications held within tamper-proof dispensing units. These also may be of future benefit, particularly for dispensing long-acting opiates such as methadone. As these new drugs and products come to market in the United States, both Medicare part D and Medicaid programs will need to consider the potential benefits, costs, and cost-savings of adding them to their formularies.

My hope is that these comments will help us think creatively about new approaches, and work diligently together to solve this grave, and still escalating problem. I look forward to a robust discussion. Thank you.

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Statement of Senator Chuck Grassley
Senate Finance Committee
"Prescription Drug Abuse: How are Medicare and Medicaid Adapting to the Challenge?"
March 22, 2012

Thank you, Mr. Chairman, for holding this important hearing today. I appreciate your leadership on this issue. The Office of National Drug Control Policy describes prescription drug abuse as the nation's fastest-growing problem, while the Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic.

According to the most recent National survey on Drug Use and Health, a survey conducted by the Department of Health and Human Services, roughly two and a half million people aged 12 and older used prescription drugs non-medically for the first time in 2010.

This averages to about 6,000 people per day abusing prescription drugs for the first time.

For Iowans, prescription drugs account for the fastest growing form of substance abuse.

Overdose deaths in Iowa from the non-medical use of hydrocodone and oxycodone pills have increased 1,233% since 2000.

Over prescription of these types of drugs strains the financial viability of the Medicaid and Medicare systems and threatens the health and wellbeing of the American people.

As health care payers, Medicare and Medicaid have a significant role to play in guiding solutions to this growing problem.

To highlight how much of an impact prescription drug abuse has on Medicaid; I want to tell you about an on-going investigation of mine.

In 2010, I sent a letter to all 50 state Medicaid Directors asking them for their top ten prescribers of the top eight most over prescribed drugs on the market.

Many states provided the data I requested, and the statistics were alarming.

For example, in Maine, the top prescriber of OxyContin wrote 1,867 prescriptions in 2009, nearly double the number of prescriptions than the second top prescriber.

This same provider also wrote 1,723 prescriptions for Roxicodone, nearly three times the number two top prescriber.

In January, I followed up on this information and wrote again to all 50 states, requesting updated data and asking the states what, if any, action they took with the top prescribers, and what systems they had in place to prevent excessive prescribing from taking place.

I also asked what, if any, training or guidance CMS has offered the states in preventing prescription drug abuse from occurring.

While the responses from the states are still being received, many states are still reporting a selection of top ten providers that are prescribing at rates double or triple that of their peers.

While some of these outliers are legitimate providers working in high-volume practices, such as mental hospitals, many cannot be explained away.

For example, the top prescriber of antipsychotics in Nevada wrote nearly 6,800 prescriptions for the drugs over 2010 and 2011 – more than ten times some of the other top prescribers identified.

For context, no individual prescriber in Colorado wrote more than 2,000 prescriptions for the same drugs over the same period. This single doctor in Nevada accounted for $2.75 million in payments from the Medicaid system.

As a result of my request, South Carolina has investigated 34 of the 83 providers who appeared on those lists for possible Medicaid abuses.

South Carolina's investigation resulted in repayments of nearly $1.9 million that more than 30 of the health care providers inappropriately billed to the state Medicaid agency.

Texas has opened investigations into dozens of the prescribers identified in the list, making several referrals for criminal prosecutions and the state licensing board.

California, Wisconsin, Tennessee, Nevada, New Hampshire, Minnesota, Kansas, Iowa, and Hawaii have taken similar actions against prescribing outliers in their Medicaid program.

The steps taken by these states highlight the aggressive role that each and every state should be taking in monitoring and investigating prescription drug practices in the Medicaid program.

Furthermore, states have overwhelmingly confirmed that CMS has been an absent partner in helping to lower prescription drug abuse in Medicaid.

I look forward to hearing from our witnesses today about what steps physicians, hospitals, states, and the federal government could be taking to curb the abuse of prescription drugs.

Not only should we put an end to the lives lost over prescription drug abuse in the Medicare and Medicaid system, we should be working collaboratively to find meaningful solutions. The cost of doing nothing is too high already.

Testimony of Billy Millwee

Deputy Executive Commissioner, Health Services Operations

Texas Health and Human Services Commission

before the

Senate Finance Committee, Subcommittee on Health Care

March 22, 2012

Good morning Chairman Rockefeller, Ranking Member Grassley, and distinguished members of the Committee. My name is Billy Millwee, and I serve as the Texas Medicaid Director. I am pleased to be with you today to offer testimony regarding the strategies Texas is using to curb prescription drug abuse in Medicaid.

Over the past several years, Texas has made great progress in managing inappropriate utilization of drugs, including pain management and antipsychotic drugs. The state has done so through successful collaboration with multiple agencies, including the Texas Medicaid program, HHSC Office of Inspector General (HHSC-OIG), Department of Family and Protective Services (DFPS), Department of State Health Services (DSHS) and the Texas Attorney General (AG).

Medicaid Drug Utilization Management Efforts

Texas Medicaid has many processes in place both on the front end--before a prescription claim is filled--and also after prescriptions are filled to help ensure appropriate utilization.

We apply numerous point-of-sale edits, or restrictions, to all outpatient prescription claims. Edits include maximum quantity limits for each drug, therapeutic duplication alerts, and an early refill edit. If a Medicaid prescription claim hits one of these edits, the pharmacist must either call our pharmacy help desk to explain why an override is needed or proactively acknowledge the edit on the claim before the claim can be adjudicated.

Texas has extensive prior authorization processes in place at the point of sale particulary of for opiate overutilization and antipsychotics. The edits help ensure that each claim for these products meets approved clinical criteria established by the Texas Medicaid Drug Utilization Review Board. If these criteria are not met, the prescriber must call the Texas Medicaid prior approval vendor to request an authorization based on the additional clinical information they provide.

Texas Medicaid also conducts retrospective Drug Utilization Review to educate prescribers. For a targeted drug therapy, HHSC identifies physicians whose prescribing practices are outside the norm, mails them a packet of information that explains the clinical criteria for the specific intervention, and lists their patients to whom the criteria may apply. Approximately six months after the intervention letters are mailed an analysis is completed to compare the prescribing practices of those physicians to a control group, to evaluate the degree of change in prescribing patterns.

Two of the letters mailed in 2010 dealt with pain medications and antipsychotics. The analysis of both of these interventions showed they made a difference in prescribing

patterns. For instance, for the letter related to Oxycodone, Roxicodone, and Xanax, by the end of the six-month study period there was a 3.2 percent decrease in the cost per patient per month for claims filled by clients of 24 high prescribing physicians that were identified in a 2010 data request by Senator Grassley. By contrast there was an 8.0 percent increase in the control group.

Inclusion of Prescription Drugs in Managed Care

Effective March 1, 2012, most of Texas' Medicaid clients will obtain both their medical and prescription benefits through the managed care service delivery model. Under this full-risk model, health plans are expected to be more aggressive with their monitoring of their providers' practices, and are contractually required to implement a drug utilization review program consistent with Medicare Part D standards.

Texas HHSC Office of Inspector General Activities

HHSC-OIG investigations arise from the receipt of a specific allegation of fraud, provider self reports, and computer data matches. HHSC-OIG performs data mining processes that use targeted queries to determine outliers and anomalies among Medicaid providers.

Of the high-volume prescribers identified in a 2010 data request from Senator Grassley, HHSC-OIG has excluded 4 from participation in the Texas Medicaid Program as a result of its monitoring program. It also has taken other enforcement actions, including

opening 39 investigations, referring 3 providers to the Office of the Attorney General for criminal prosecution, and referring 2 providers to licensing boards for action.

Increased Surveillance and Prosecutorial Presence

Inter-agency collaboration recently enabled the successful prosecution by the Texas Office of Attorney General of a major drug manufacturer for falsely promoting an antipsychotic medication and marketing it for use in children. The prosecution led to a $158 million settlement this year.

Psychotropic Medication Monitoring for the Foster Care Population

Since 2005, Texas has taken concerted steps to encourage the appropriate prescribing of psychotropic medications, including antipsychotic medications, among children in foster care who are prescribed these medications at a significantly higher rate than other children in Medicaid.

In 2005, the Texas Health and Human Services agencies released the Psychotropic Medication Utilization Review Parameters for Foster Children. These guidelines, which are widely distributed and periodically updated, guide utilization review of these medications for the foster care population.

In 2008, Texas implemented the STAR Health statewide managed health care system to provide comprehensive health care for Medicaid youth in foster care. STAR Health includes a medical home model, electronic health passport, and ongoing Psychotropic

Medication Utilization Reviews based on the guidelines to monitor clinical psychiatric prescribing.

Since 2005 and likely as a consequence of these changes, prescribing of psychotropic medications in the foster care population has been on a downward trend. Every year, the use of psychotropic medications in Texas foster care continues to decrease, from 29.9 percent in Texas State Fiscal Year (FY) 2004 to 20.6 percent in FY 2010 for children prescribed psychotropic medications for 60 days or more. This decrease represents a 31 percent reduction in usage.

Health Information Technology

Texas Medicaid is moving forward with e-prescribing and a Medicaid electronic health record. HHSC also is participating in statewide efforts related to health information exchange. All of these efforts help prescribers see patients' medication history at the point-of-care to help them make more informed prescribing decisions and these technologies may be leveraged to help curb prescription abuse.

Coordination with CMS

Texas welcomes coordination with our federal partners at the Centers for Medicare and Medicaid Services (CMS) on the issue of prescription abuse. As the federal Medicaid oversight agency, CMS could make technical assistance available to state Medicaid programs on this issue and also help to disseminate best practices. States also may benefit from greater coordination between Medicare and Medicaid, such as sharing

information about providers who participate in both programs who are suspected of prescribing inappropriately so that both programs can take timely action.

Summary

In conclusion, Texas has multiple programs in place and has completed several efforts to reduce fraud and over-prescribing of prescription drugs. We will continue to evaluate our programs and procedures to help ensure they recognize changes in practices by prescribers that are intent on committing fraud and will take strong action when fraud, waste, or abuse is suspected.

We can and will do more and are encouraged by the work of you and your committee to support the efforts of Texas and other states to address this issue.

Statement of Senator Jay Rockefeller
Senate Finance Subcommittee on Health
Prescription Drug Abuse: How are Medicare and Medicaid Adapting to the Challenge?
March 22, 2012

Today, we're here to talk about an epidemic of drug abuse that is ripping apart families in my state of West Virginia and in communities across the country.

Simply put, prescription drug abuse is what happens when prescription drugs are used for non-medical purposes. Opioid painkillers, antipsychotics, or stimulants are most commonly used.

The Centers for Disease Control has termed prescription drug abuse an "epidemic." Overdose from prescription painkillers is now one of the leading causes of accidental death in the United States. In West Virginia, between 2001 and 2008, the death rate of overdoses involving legal prescription drugs more than quadrupled.

And for every death, the CDC tells us there are 10 treatment admissions for abuse, 32 emergency department visits, 130 people who abuse or are addicted to these drugs, and 825 non-medical users.

There is no single solution for stopping this crisis.

Today, we'll hear some stories that might shock and sadden us. But we will also hear about some practical solutions.

Prescription drug abuse is not just some sensational thing that happens to celebrities like Heath Ledger or Michael Jackson – who died before their time from tragic overdoses.

The fact is, prescription drug abuse touches people from all walks of life. It is about ordinary people – like a polite, stoic elderly man from rural West Virginia – who can't be here today.

His story, thank goodness, has a happy ending – thanks to the primary care doctor he visited. When she asked why this man was taking a powerful opioid painkiller, he said he had some chronic lower back pain. So his doctor took him off the drug. Turns out, this man had been addicted without even realizing it. But now that he is off this powerful painkiller, he is more clear-headed, and without all the side effects he'd been feeling from taking a drug that was not necessary for him.

Now, of course, prescription drugs can and do work wonders for millions of people. And for people with conditions like chronic pain or severe mental illness, prescription drugs can be a godsend. But, the availability of powerful prescription drugs has in some ways gotten ahead of our ability to prescribe them safely.

Prescribers don't have the tools they need, such as prescription drug monitoring programs that work across state lines. And patients need better education so they are sure how to use powerful prescription drugs correctly.

Sadly, because prescription painkillers, stimulants and antipsychotics are so powerful and so addictive, they are all too often the target of criminals. These criminals are worse than ordinary fraudsters – they not only steal taxpayer dollars through fraudulent schemes like "pill mills" or fraudulent prescriptions. They also feed people's addictions and prey on their pain. And that must stop.

But prescription drug abuse is not limited to fraud, and we do ourselves a disservice if we ignore the significant clinical implications of this problem. So today we will hear from our expert panel about the range of solutions we can implement in Medicare and Medicaid to stop prescription drug abuse.

They will help us answer important questions, such as:

- **What tools and support systems do doctors, nurses and other prescribers need** to make sure people get the right care when it comes to controlled substances?

- **How can Medicare and Medicaid help educate patients and coordinate care so that prescriptions are used correctly?**

- **Are we adequately identifying people at risk of addiction to controlled substances?** What happens when someone is found to have an addiction?

- **Are there new models of treatment we should consider testing in Medicare and Medicaid?**

- **Can existing fraud-detection systems help us tell** the difference between deliberate fraud, addiction-driven behavior, and uncoordinated care that leads to beneficiaries obtaining prescriptions from multiple sources?

There are no simple solutions. But we can make progress. I have introduced legislation to improve the tools available to prescribers – including better training on controlled substances and prescription monitoring programs – so we can start to turn the tide.

I look forward to hearing from our witnesses today, and I will submit my full statement for the record.

With that, I turn to my friend, the distinguished senior Senator from Iowa, Senator Grassley, who is also very passionate about this issue.

Testimony

for

Senate Finance Committee
Subcommittee on Health

Prescription Drug Abuse: How are Medicare and Medicaid Adapting to the Challenge?

by
Timothy Schwab, M.D., FACP
Chief Medical Officer
SCAN Health Plan

March 22, 2012

I. Introduction

Chairman Rockefeller, Senator Grassley, and members of the subcommittee, I am Dr. Tim Schwab, Chief Medical Officer at SCAN Health Plan (SCAN). SCAN is the fourth largest not-for profit Medicare Advantage plan in the United States, serving approximately 130,000 members in California and Arizona. While most of SCAN's members are over the age of 65, we also provide care to some younger, disabled individuals who are dually-eligible for Medicare and Medicaid benefits.

We appreciate this opportunity to testify on the innovative programs that SCAN has in place to protect our members from the dangerous effects of prescription drug abuse. Medicare Advantage plans play an important role in preventing and detecting this type of activity. Our testimony includes the following:

- A brief background on SCAN and the population that we serve;
- Challenges relating to prescription medications that currently confront the frail elderly;
- The programs that SCAN has in place to assist our frail elderly members in accessing the appropriate pharmaceutical care; and
- The fraud and abuse prevention efforts that SCAN employs to ensure proper member adherence and safety.

II. Background on SCAN Health Plan

SCAN has a long history of serving older adults with complex health situations. SCAN was founded in 1977 by a group of Long Beach, California senior citizen activists who were frustrated by a lack of access to health and social services that addressed their specific needs. SCAN's mission today is the same as it was then: to develop innovative ways to help our members manage their health and live independently. For more than two decades, SCAN participated in Medicare's Social HMO Demonstration, incorporating a home and community-based services (HCBS) benefit together with a comprehensive program of assessment and care management. It was through our experience as a Social HMO that SCAN developed an expertise in managing the health needs of particularly sensitive populations.

Sixty percent of all SCAN members have three or more chronic conditions. Those individuals receiving case management services are usually taking eight or more medications. Because of the complex nature of our members' health conditions, SCAN has created a care management model that emphasizes prevention and early intervention, with a keen focus on medication management. Our model spans the continuum of a beneficiary's health status, providing the right care at the right time. Disease management programs focus on the patient's disease-state, including disease process and management, recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, nutrition, self-management and healthy behaviors, advance care planning and, of course, medication management. Highly-trained care teams address the complex needs of the chronically ill population, and each program

is coordinated with all others to ensure absolute care transitions between all levels of care and providers in the integrated health care delivery system.

Recent analyses of SCAN's care management model demonstrate its effectiveness in improving patient health outcomes. A soon-to-be published study conducted by Avalere Health comparing HEDIS 30-day All-Cause Readmissions Rates between dual eligibles enrolled in SCAN Health Plan versus Medicare fee-for-service (FFS) dual eligibles found that SCAN's dual eligibles had a hospital readmission rate that was 23 percent lower than a similar cohort of California FFS dual eligibles. This same Avalere study also found that SCAN scored better than Medicare FFS on ARHQ's Prevention Quality Indicator (PQI) Overall Composite, demonstrating a 15 percent lower hospital inpatient admission rate for conditions that compose the composite measure, including chronic obstructive pulmonary disease (COPD), congestive heart failure, and bacterial pneumonia. The *New England Journal of Medicine* has cited SCAN's model as an example of a successful investment in primary care to provide better care at reduced costs through reductions in the use of hospitals and emergency rooms.[1] We know our success is based on case management, with medication therapy management being one of the pillars of our success.

III. Prescription Medications Challenges that Confront the Frail Elderly

High quality scores such as the ones cited above are the result of a system that puts the patient at the center of care. At SCAN, managing complex medication regimens is a primary focus across the case management spectrum. That is less true in traditional Medicare, where a patient with multiple physicians and complex, co-morbid conditions may take a variety of medications that unfortunately can lead to negative drug-to-drug interactions. How does this happen? Providers might prescribe additional medications to treat a patient's new symptoms as they arise, without routinely reviewing seniors' medication profiles to determine whether some of their medications should be discontinued. This practice can lead to the overprescribing of medications that may result in hospitalization and, in some circumstances, even death.

Other cases are less preventable. A patient may experience a traumatic health episode, such as a car accident, surgery or the onset of a debilitating disease such as cancer. Medication prescribed to relieve their pain and suffering occasionally may have the unintended consequence of causing addiction. Sometimes a patient's genetic pre-disposition or personal problems lead to abuse of narcotics. These challenges only emphasize the importance of ensuring that this population receives proper coordination of care, which would facilitate communication between prescribing physicians and reduce the potential for over-prescribing and medication abuse. Models such as SCAN's case management program pair care coordination with utilization management services to ensure patient safety.

IV. SCAN's Pharmaceutical Care Avoids Dangerous Drug Interactions

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[1] Bodenheimer T, Berry-Millet R. (2009) Follow the Money – Controlling Expenditures by Improving Care for Patients Needing Costly Services. New England Journal of Medicine, 361:1521-1523.

To address the complex needs of frail, high-risk individuals, SCAN directs considerable attention and effort to the critical issue of medication management. As mentioned above, it is not uncommon for a SCAN member to be taking eight or more medications, making management of these various prescriptions and their potential interactions difficult. In addition, a number of non-geriatric-friendly medications still prescribed by practicing physicians put our members at particular risk for dizziness, falls, and motor vehicle accidents. With these risks in mind, SCAN has implemented a number of medication monitoring and management programs designed to alert members, and to advise physicians if members are at risk, so that changes can be made to the patient's drug regimen.

- *Medication Therapy Management Program (MTMP)*: The MTMP is integrated with SCAN's case management program to ensure that all aspects of the member's health are addressed and that medication therapy is appropriate to the patient's various health needs. The program is delivered collaboratively by SCAN's clinical pharmacy and case management staff. Pharmacy staff review high risk members' medication profiles on a regular basis to identify drug-related issues such as therapeutic duplication, medications prescribed to the member that are inappropriate for use by the geriatric population, potential drug/drug or disease interactions, multiple prescribers, compliance, and potential drug overuse. When a concern is identified (e.g., a member lacks a system for organizing their medications, a member is not educated on the reason for taking each medication), the member's case manager is notified and provides appropriate counseling and assistance. In addition, a clinical pharmacist communicates with the member and the member's prescribing physician in writing a plan to resolve any drug therapy issues to ensure positive outcomes from medication use.
- *Concurrent Drug Utilization Reviews*: SCAN conducts pharmacy point-of-sale audits to prevent therapeutic duplication, appropriate dosing, etc.
- *Retrospective Drug Utilization Reviews*: After reviewing pharmacy claims that have been processed, SCAN notifies the member's physician retrospectively if the member has filed duplicative therapies (i.e. from different providers) or filled senior-inappropriate medications. This allows the physician to review the risk of the medication versus the possible benefit.
- *Formulary Review*: SCAN ensures that drugs covered on the formulary are clinically effective in the senior population and have appropriate utilization management, when applicable.
- *Medication Error and Identification Reduction*: Controls are in place to identify and track potential medication errors and to take action to ensure appropriate pharmaceutical care.
- *Member Education Initiatives*: SCAN conducts informational outreach initiatives to ensure that our members are aware of ways to save money on their prescriptions through the use of lower cost, therapeutically-equivalent generic drugs.
- *Continuing Medical Education (CME)*: SCAN is an accredited provider of CME, and supports a web-based platform of educational modules and tools for our contracted provider networks. Each module includes a medication management component. Modules include: Depression, Pain Management, Treatment of COPD, and Stroke Prevention.

SCAN employs a staff of nearly 200 case managers who work with members on an ambulatory (via our Geriatric Health Management program) and on an inpatient basis. Case managers assist members in managing chronic illnesses and understanding the purpose of their medication regimens. They work with patients who are transitioning from hospital to home to alleviate confusion about newly-prescribed medications and reduce the risk of re-hospitalization. Our case managers also review prescriptions and help members set up systems to manage their medications, while alerting members to the risks associated with medication misuse. Finally, case managers bring the cases of particularly frail, high-risk members to the interdisciplinary team (IDT), where issues are addressed in conjunction with social workers, pharmacists, behavioral health specialists, and physicians with geriatric expertise. These professionals collaborate in the creation of an individualized care plan, which is then discussed with the member's primary care physician and specialist(s) to ensure coordination and the provision of geriatric-friendly care.

V. Preventing Fraud and Abuse and Ensuring Patient Safety

SCAN has in place a comprehensive Medicare Part D Fraud, Waste, and Abuse (FWA) program to detect and manage fraudulent behavior. SCAN's FWA program leverages data mining programs, FWA identification software, and special reports designed to allow a qualified reviewer to determine whether prescribing patterns are appropriate. It can identify potential problem pharmacies, as well as members with unusual or excessive prescription utilization patterns. SCAN's FWA program encompasses all potential prescribers, including physicians, dentists, physician assistants, and nurse practitioners.

These issues can best be illustrated by the case history of a SCAN member who contacted Member Services eight times over a four-day period to obtain an override exception for a pain medication refill. SCAN Member Services felt that case management should reach out to the member to ensure that his pain was being adequately-managed and to address any possible prescription misuse. This case was also referred to case management via a parallel process that exists at SCAN: a report provided by our pharmacy benefit manager, Express Scripts, that suggested possible medication misuse.

Upon review of the member's encounter data and pharmacy claims, it was determined that the member suffered from depression, anxiety, and chronic pain, and had sought out multiple prescribers for his pain medication. Collaboration with the member's primary care physician (PCP) revealed that the member was visiting the PCP's office daily, calling regularly, and continuing to visit various pharmacies seeking refills for his prescription. The PCP's office reported that the member would often arrive in a "drunken state," and appeared to "have an addiction to pain medication and under the influence of drugs." The member's clinical reviews were promptly submitted to a SCAN RN Behavioral Health Specialist and to the clinical pharmacy team, as well as to SCAN's interdisciplinary team.

The IDT connected the member with a new primary care physician group in order to address pain management and concerns regarding the patient's frequent ER visits for additional medication. The IDT recommended cognitive and depression screenings, and that the member's new PCP assess whether psychiatric referral was needed. The IDT directed case management to

notify the member's new medical group about a possible history of substance abuse, and to share his medication profile. In addition, IDT directed that a SCAN Medical Director assist in contacting the medical director of the new group regarding concerns about the member's medication usage. It also recommended that SCAN's Pharmacy team consider the possibility of flagging the member in the team's system so that future refill attempts and ER visits would appear. A SCAN case manager updated the member's new PCP and medical group on behalf of the member, continued outreach to the member, and encouraged the new PCP to conduct outreach to all prescribing physicians and to act as the single point of contact unless pain management would be appropriate and referred. SCAN also contacted Adult Protective Services, and continued to collaborate with the medical group to best support the member. Work with the member and his care team is ongoing.

Over the past nine months, SCAN has received 18 referrals for potential Part D fraud, waste, and abuse activity. Seven of these referrals were substantiated, seven were unsubstantiated, and four are still pending. SCAN's FWA program includes several types of audits:

- *Next Day Desk/Phone Audits*: provide for claim review prior to billing, so that the pharmacy will not receive an erroneous submission
- *Historical Desk/Phone Audits*: allow for audits outside of the Next Day process
- *Field Audits* (on-site): conducted at the pharmacy location, these include a thorough review of claims and quality assurance documentation
- *Investigative Audits*: identify and research fraud within pharmacy networks
- *Beneficiary verification*: asks the beneficiary to verify a list of all the prescriptions processed for him or her / his or her family at specific pharmacies
- *Physician verification*: to ensure the accuracy of information on a claim, a letter is sent to the prescribing physician

In conclusion, these challenges reinforce SCAN's strong belief that Medicare beneficiaries, particularly the frail elderly, need coordinated, integrated care to assure their safety regarding prescription medications. The greatest danger to patients is neither fraud nor abuse, but the unintended consequences of drug-to-drug interactions that can harm patients as our medical system is striving to help them. Models that the put the patient at the center of care can go a long way in assuring they receive the medication therapy that truly benefits them.

COMMUNICATIONS

Statement for the Record Submitted on Behalf of

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United States Senate Committee on Finance
Subcommittee on Health Care

Hearing on "Prescription Drug Abuse:
How are Medicare and Medicaid Adapting to the Challenge?"

March 22, 2012

Ameritox, Inc. (Ameritox) appreciates the opportunity to submit this written statement for the record of the March 22, 2012, U.S. Senate Committee on Finance Subcommittee on Health Care hearing entitled "Prescription Drug Abuse: How are Medicare and Medicaid Adapting to the Challenge?" Ameritox applauds the Subcommittee's Leadership and Members for holding this hearing to address the problem of prescription drug abuse. Ameritox provides critical medication monitoring services to help solve this epidemic. Unfortunately, recent actions by Medicare contractors have put stringent restrictions on these services. We call on Congress to ensure continued access to medication monitoring services.

Millions of Americans suffer from debilitating chronic pain, and appropriate use of pain medications provides patients with the relief they need to lead productive lives. A major component of assuring quality of care for chronic pain is appropriate management of opioids and other controlled drugs. However, the legitimate use of long-term pain medication is undermined by the possibility of addiction, substance abuse, diversion of medications, and overdose leading to coma and/or death.

According to the Office of National Drug Control Policy (ONDCP), prescription pain medication abuse is now the second most common illegal drug problem in the nation. Last year, more Americans died from misuse of prescription opioids than from heroin and cocaine combined.[1] Additionally, from 1999 to 2006, hospitalizations for poisoning by prescription opioids, sedatives, and tranquilizers increased by 65 percent.[2] Unfortunately, drug misuse, abuse, and diversion are major health and economic problems that have not been effectively addressed.

Physicians need sophisticated tools to help confront this problem and to ensure that their patients are taking their medication appropriately. Medication monitoring using periodic urine testing provides physicians with critical insights into the use of pain medication, as well as identifying other

[1] Centers for Disease Control and Prevention, July 2010, Unintentional Drug Poisoning in the United States (www.cdec.gov/home and recreation safety/poisoning).

[2] Coben, J.H. *et. al.* (2010) Hospitalization for poisoning opioids, sedatives, and tranquilizers. *American Journal of Preventive Medicine*, 38(5), 517-524.

legal and illegal drugs possibly being used by their patients. As a leader in providing medication monitoring tests, Ameritox has considerable expertise utilizing advanced clinical laboratory technologies, which hold significant potential to address the problem of diversion.

Medication monitoring is an established standard of care for chronic pain patients on opioid therapy and is endorsed by multiple professional societies (e.g., the American Pain Society and the American Academy of Pain Medicine), the Department of Defense, and the Veterans Health System. In addition, State laws in Utah, Louisiana, Washington, and Texas support periodic urine drug monitoring as a standard of care for patients receiving opioid therapy for chronic pain.

Expert guidelines and state regulations are based on research that shows that physicians alone cannot reliably assess the potential for their pain patients to be misusing, abusing, or diverting controlled drugs. A study from Brigham and Women's Hospital, published in the *Clinical Journal of Pain* in 2002, demonstrated that physicians miss at least 30 percent of cases of patients taking illicit or non-prescribed controlled drugs (verified by urine drug testing) when they used clinical judgment alone.[3]

Physicians routinely use medication monitoring tests as part of the management of chronic patients to help ensure that patients are receiving the prescribed regimen of medications, taking their medication as directed, gaining positive outcomes, and not diverting their medication for other uses. These tests are performed in sophisticated laboratories and provide crucial information to physicians who order these tests.

Medication monitoring should be highly cost-effective for Medicare and the health care system. A recent study published in the *American Journal of Managed Care* analyzed the prevalence and cost of chronic opioid therapy, as well as the economic impact of compliance with pain medication regimens. The study demonstrated that the average total annual medical spending for patients on chronic opioid therapy was over $23,000 per year (2008 dollars). Patients who were adherent to their opioid regimen had costs that were approximately $3,400 (12%) per year lower than non-adherent patients.[4] Medication monitoring helps physicians identify potential interactions with other legal prescription medications and over-the-counter remedies, which saves the health care system millions of dollars every year in unnecessary hospital admissions due to drug poisonings from the use of multiple medications.

Despite the importance of these tests to patients, physicians, and the Medicare program, recent actions by local Medicare contractors threaten to greatly reduce access to medication monitoring. A number of recent Local Coverage Determinations (LCDs) have put stringent restrictions on patient and provider access to critical pain medication monitoring services. These policies interfere with a physician's clinical judgment in managing a patient's chronic pain and reduce the quality of care. The LCDs are inconsistent with clinical practice and standards, the recommendations of

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[3] Katz N, Fanciullo G, et al. The role of urine toxicology testing in the management of chronic opioid therapy. *Clinical Journal of Pain.* 2002;18;S76-82.

[4] Leider HL. Healthcare costs and nonadherence among chronic opioid users. *Am J Manag Care.* 2011;17(1):32-40.

professional societies, state laws and regulations, and the coverage policies of several federal agencies. We strongly urge Congress to oppose implementation of these damaging LCDs.

Ameritox strongly supports the Subcommittee's efforts to highlight the growing problem of prescription drug abuse in Medicare and Medicaid and to identify potential solutions. Ameritox believes that medication monitoring tests are an important tool to prevent such abuse and would welcome the opportunity to serve as a resource to federal policy-makers. Thank you for your consideration of our views, and please feel free to contact us for any additional information that may be helpful to the Subcommittee.

Sincerely,

Harry Leider MD, MBA, FACPE,
Chief Medical Officer and Senior Vice President

TESTIMONY

Written Testimony for the Record submitted by:

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For the U.S. Senate Committee on Finance
Subcommittee on Health Care hearing on
Thursday, March 22, 2012:

Prescription Drug Abuse: How are Medicare and
Medicaid Adapting to the Challenge?

Chairman Rockefeller, Ranking Member Grassley, and other distinguished Members of the Subcommittee. I am Lee S. Arian, staff Vice President of Financial Operations, Data Mining, and Investigations for WellPoint, Inc. and I oversee the company's fraud and abuse department. Previous to joining WellPoint, I spent thirteen years as an Assistant United States Attorney in Los Angeles, California, where I was a part of the Criminal Division's Public Corruption and Government Fraud Section. For three years, I served as the Health Care Fraud Coordinator, establishing the office's health care priorities, implementing an investigative and prosecutive plan to combat health care fraud, and acting as liaison with the Department of Justice on health care matters.

Thank you for the opportunity to provide written testimony on behalf of WellPoint on a critically important issue that often yields tragic results: prescription drug abuse in the health care delivery system. WellPoint appreciates the leadership and efforts of Chairman Rockefeller in addressing prescription drug abuse, such as the Prescription Drug Abuse Prevention and Treatment Act of 2011, and the work of other committee members. WellPoint respectfully offers our input and recommendations to protect both patient safety and the financial viability of our health care system.

As the largest health benefits company in terms of medical enrollment, with more than 34 million lives, WellPoint believes that it is critical to address health care fraud and abuse. In a time of rising health care costs, it is essential to stop the flow of money funding illegitimate uses of prescription drugs. The National Health Care Anti-Fraud Association estimates that financial losses due to health care fraud and abuse range from $70 to $234 billion a year — about $190 to $640 million per day. However, the cost goes beyond the billions of dollars consumers, payers and the government spend unnecessarily. It also puts consumers' health at risk. For example, the steadily increasing incidence of physicians overprescribing narcotics that are not medically necessary contributes to inappropriate drug use by teenagers, patient overdoses and even death.

In order to truly make inroads into the problem of fraud and abuse associated with prescription drugs, a holistic view needs to be adopted, since the enormous costs of health care fraud are borne by all Americans whether they have private health insurance coverage or government-provided health care. Moreover, it is clear that many of the same individuals and entities that perpetrate fraud against government health care programs also engage in fraudulent activity in the private health insurance industry. Thus, the most effective way to address prescription drug fraud and abuse is to forge a close and active partnership between private health plans, government agencies, and the provider community. Fraud and abuse affects both publicly funded health care programs and privately funded health benefits — and it is only through cooperation and collaboration between the public and private sectors that the problem can be meaningfully addressed.

In addition, it is important to understand that stopping prescription drug fraud and abuse means that multi-faceted approaches need to be used, as there is more than one problem and more than one source. For example, drug fraud or abuse can be caused by overutilization (drug abuse) or fraudulent prescribing (for financial gain), and can be driven not only by the recipients of the drugs but also by prescribing providers. For this reason, it is important to recognize that a one-size fits all solution does not exist. WellPoint stands ready to share with policymakers the range of experience we have in fighting prescription drug fraud and abuse and to work together with Congress, the Administration, and the agencies of jurisdiction to improve our partnership in this regard.

One of the significant strengths that WellPoint and other health plans provide is the data available from our integrated health care delivery system. This allows us the ability to see the entire health care spectrum and spot trends and outliers – such as the overprescribing physician or the patient receiving multiple prescriptions from multiple providers or pharmacies. For WellPoint's members that have both pharmacy and medical coverage under WellPoint, we have been able to identify:

- Members in crisis or at risk of harmful prescription drug use, including abusive or potentially addictive usage patterns;
- Members who may benefit from chemical dependency and/or pain management intervention to improve quality of life;
- Provider practice patterns regarding the overprescribing of medications; and
- Criminal enterprise and/or individuals defrauding the health care system, through the work of our fraud and abuse Special Investigations Unit (SIU)

Our goal at WellPoint is to prevent prescription drug fraud and abuse for the benefit of our members' health, as well as for the health care system as a whole. In order to meet this goal, WellPoint has developed numerous programs to identify prescription drug abuse and to intervene when appropriate.

WellPoint's Fraud and Abuse Programs

In our Medicaid managed care plans, Medicare Part D programs and commercial business, we have implemented our Controlled Substance Utilization Monitoring (CSUM) Program in which we identify members that meet certain drug utilization parameters that may indicate a pattern of potential misuse (i.e., 10 or more claims for controlled substances, excluding medications for multiple sclerosis or oncology, within a 90 day period). Once a member is so identified, a letter is sent to each prescribing practitioner and includes a list of the controlled substance prescriptions the member has filled, and who has prescribed those medications. The goal is to make the prescribing provider aware of the overall medication use pattern of the patient, and to identify any inappropriate drug regimens or potentially abusive drug-use practices. In calendar year 2011, WellPoint saved approximately $5.7 million in tracked savings from CSUM letters sent to prescribing providers. Specifically regarding pain management, beginning in March of this year, we will alert providers in Ohio and Wisconsin when their patients are using higher levels of Opioid medications than what might be considered within normal limits. Letters will be sent when patients have received 10 or more controlled substance prescriptions within three months (excluding patients with cancer and multiple sclerosis). The letters reference WellPoint's new pain management website, a comprehensive resource intended to give providers the tools and information to help manage their patients' drug regimens more effectively.

In addition to our commercial lines of business, WellPoint has also implemented a restricted recipient program for our Medicaid plan in Indiana called "The Right Choices Program" in which a member who has been identified as an abuser or at risk for abuse of controlled substances can be locked into using only one primary care physician, one retail pharmacy, and one hospital for any non-emergency care. The goal is to prevent members who have exhibited a pattern of obtaining multiple prescriptions for controlled substances and multiple dispensations of these medications from continuing to obtain inappropriate amounts and dosages of drugs through their health care coverage. Our Case Managers, who work specifically with the "Right Choices Program" membership, work directly with providers and members regarding excessive controlled substance use. Once a member is placed in the program, the Primary Medical Provider must approve all referral providers for the member. Efforts are made to

connect members with Behavioral Health Providers, Case Managers and Community Resources related to abuse and addictions.

WellPoint also applies quantity limits and prior authorization that support the FDA approved indication, recommended dosage and safety concerns. These limits and utilization management requirements apply to opiods and narcotic combination products to ensure clinical appropriateness at the point of sale.

WellPoint's Special Investigations Unit

To enhance our fraud and abuse efforts, WellPoint has a dedicated fraud and abuse prevention team known as the Special Investigations Unit (SIU). The SIU is staffed with employees having prior experience in the FBI, state law enforcement, and state insurance department fraud units. Medical professionals, including doctors and nurses, who have clinical and coding expertise, also work within the SIU. Finally, the data analysis team is comprised of individuals with IT or other computer-related backgrounds. The investigators are responsible for investigating assigned cases in order to detect fraudulent, abusive or wasteful activities/practices and recover funds paid on fraudulent claims.

Our programs at WellPoint also include collaborative efforts between our SIU and our contracted pharmacy benefit manager, Express Scripts, to identify retail pharmacies colluding with over-prescribing or inappropriate prescription patterns and to exclude such pharmacies from our provider networks.

Operation Pillbox

Operation Pillbox is an example of a recent, ongoing initiative by WellPoint's SIU to identify providers who engage in unsafe practices that defraud insurers.

WellPoint's SIU launched Operation Pillbox in 2007, when our investigators noticed unusual prescribing patterns involving end stage cancer drugs. Our investigators, working on behalf of our California health plan, determined that a number of physicians were prescribing an unusually large quantity of a very strong narcotic meant to treat cancer patients with severe pain. Their research found that just 10 physicians prescribed more than a quarter of that drug in the entire state, with some patients receiving more than $200,000 worth of the medication, despite no clinical evidence that the patients had cancer.

The team then expanded their research to include other Schedule II narcotic drugs (such as oxycontin). They discovered that some physicians were prescribing these potentially addicting and life-threatening drugs with little or no medical justification. Believing that the suspect physicians may have been involved in the illegal sale and distribution of narcotics, WellPoint's investigators shared our information regarding the physician's background and prescribing patterns, the pharmacies involved, and the patients receiving the largest volume of the prescriptions with local, state, and federal law enforcement authorities. As a result, several of the physicians identified by Operation Pillbox have been arrested and criminally charged or stripped of their medical licenses. One of the physicians was linked to the overdose deaths of thirteen of his patients.

WellPoint's Recommendations:

Based on our experience in combating prescription drug fraud and abuse in health care delivery, WellPoint offers the following recommendations:

Medicare Restricted Recipient Program

WellPoint is supportive of giving CMS the authority to establish a restricted recipient program for Part D for those beneficiaries displaying a pattern of mis-utilization, as this is something that health plans are doing in other lines of business. We also recommend that plan sponsors be permitted to report beneficiary-specific concerns—based on objective, standardized metrics—to CMS or to Medicare Drug Integrity Contractors (MEDIC) for appropriate action against the individual beneficiary. To ensure members' safety, WellPoint believes that plans should not implement policies of denying a prescription fill even in cases of suspected overutilization. We ask that CMS be responsible for taking any enforcement action once members suspected of misuse or overutilization has been identified by the plan sponsor.

Furthermore, WellPoint supports flexibility for plans in their implementation of fraud and abuse detection processes. We note that one model will not work for all plan types; for instance, stand-alone PDPs will need to deploy processes differently from coordinated care MA-PD plans. Rather than articulating detailed protocols in statute or regulation, we suggest that plans be permitted to file a program description subject to certain, articulated parameters, which could be approved or denied by CMS.

Dual Eligible Beneficiaries

Through our experience in providing health care coverage through both our Medicaid state-sponsored programs and Federal programs, we have observed that a large portion of the opioid and controlled substance abuses in the Part D program occur among the dual eligible population – beneficiaries eligible for both Medicare and Medicaid and often under 65 years of age (in calendar year 2011 alone, WellPoint's SIU unit tracked 34 investigations of Medicare Part-D beneficiaries under the age of 65). Under the current law, dual-eligible beneficiaries are allowed to change plans on a month to month basis, which permits drug seekers to switch programs frequently in order to avoid detection and escape program edits or substance abuse programs.

WellPoint recommends that dually eligible beneficiaries with evidence of drug-seeking behavior should additionally be locked into one managed care plan, rather than continue to be allowed to switch plans on a monthly basis to evade suspicion.

Improved Partnerships

WellPoint supports better coordination and cooperation among CMS, DOJ, and all stakeholders. WellPoint supports the development of a plan by all stakeholders, and stresses that plans sponsors should be included in the development of such a plan. Right now there is little collaboration between the agencies and the health plans that oftentimes have the information, experience and expertise necessary for preventing and fighting fraud and abuse. While health plans currently share information with the MEDIC, we are rarely informed of the ultimate result, and information collected by the agency is rarely shared with our fraud and abuse detection teams.

However, WellPoint is concerned that any requirements for health plans to share data with other plans regarding the record and actions generated by overutilization review (e.g., the record from the retrospective DUR review/case management, as well as beneficiary-specific POS edits) could have negative unintended consequences.

As a threshold matter, it will be administratively burdensome for plan sponsors and it may also have negative unintended consequences for the beneficiary. For instance, if a beneficiary changed plans because he felt he was being unjustly targeted by his prior plan when in fact he had an underlying medical condition that warranted his drug utilization, the beneficiary may face continued barriers in obtaining needed treatment if the new plan is beholden to information provided by the prior plan.

Instead, each plan sponsor should be encouraged to put its own practices in place to appropriately screen new members, rather than being required to act on information that they do not have firsthand, verifiable evidence to support. Furthermore, WellPoint recommends that CMS and the MEDIC have responsibility for maintaining this information and sharing it with appropriate agencies and plan sponsors. WellPoint also recommends extending the application of data-sharing efforts to providers identified as potentially fraudulent.

Minimum Loss Ratio

In order to alleviate the time, effort and expense required for the greater detection and curtailing of fraud and abuse in the health care system, such expenses should not be accounted for as administrative expenses under the MLR calculation.

All expenses for health insurer anti-fraud and abuse programs should be included as "activities that improve health care quality" in the MLR calculation, since they reduce waste in the health care system, reduce the cost of health care, and enhance patient safety by helping to remove from the system health care providers and individuals engaging in unsafe and fraudulent practices.

The MLR final regulation merely gives insurers a limited credit – up to the amount of fraud recoveries – for fraud prevention activities. In essence, this means that insurers will have to count as administrative expenses their largest portion of antifraud expenses -- those dedicated to fraud prevention. It is truly puzzling that at a time when the federal government is accelerating its efforts to prevent fraud in Medicare and Medicaid, it has simultaneously issued a regulation that will serve to discourage health insurers' fraud prevention efforts. Ironically, eliminating anti-fraud programs will tend to increase MLR percentages because claims will be higher, but an increased MLR will be at the expense of patient safety, quality of care, and controlling health care costs, which are the very aims of the Affordable Care Act. If private health insurers are discouraged from keeping their anti-fraud programs in place at the same time that public program anti-fraud efforts are increasing, federal law enforcement will lose a valuable source of information and tips about providers and recipients who may also be engaging in defrauding public programs. These considerations will also be crucial as the Centers for Medicare and Medicaid Services (CMS) codifies and implements the ACA's MLR for Medicare Advantage.

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In conclusion, WellPoint would like to thank the committee for the opportunity to submit this written testimony and pledges its support in any efforts to make the health care system financially viable and safer for our members.

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