



February 16, 2018

The Honorable Orrin Hatch

United States Senate
Chairman; Senate Committee on Finance
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden

United States Senate
Ranking Member; Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

Submitted electronically only via opioids@finance.senate.gov

RE: Response to Senate Finance Committee Request for Input on Ways to Alleviate the Opioid Epidemic

Dear Chairman Hatch and Ranking Member Wyden:

We applaud Senate Committee on Finance leadership for their commitment to assessing a range of policy options aimed at alleviating the opioid epidemic. *Centerstone* is one of the nation's leading not-for-profit providers of mental health and substance abuse services, delivering evidence-based care to over 170,000 individuals throughout Florida, Tennessee, Illinois, Indiana, and Kentucky. With over 60 years of on-the-ground experience, supported by outcomes research generated by the *Centerstone Research Institute*, we are able to identify the most significant barriers to offering timely and safe care to those with opioid use disorder (OUD) and other substance use disorders (SUDs).

Pursuant to your request, our below recommendations are limited to those we believe will improve patient outcomes, are fiscally responsible, can generate bipartisan support, and may lead to an increased likelihood of Committee action.

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

Below, we identify suggested changes in reimbursement structures, consumer safeguards, and incentives that will lead to improved patient outcomes, while utilizing the healthcare workforce more efficiently and effectively.

- **Ensure that reimbursement protocols reward trusted providers and incent patient outcomes.** Lawmakers should take steps to ensure that federal dollars are not misused by inadvertently flowing federal funds to “MAT pill mills¹,” which offer suboptimal care to patients and may even exacerbate the problem dedicated providers are aiming to fix. Furthermore, as more rogue actors move into this space, quality providers are experiencing increasing levels of denials while administering sound, evidence-based addiction treatments to individuals. This combination of

¹ <https://www.courier-journal.com/story/news/investigations/2017/06/08/rogue-doctors-hands-medicine-designed-treat-addiction-turns-into-new-habit/98522426/>



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MAT pill mills and increased burden for quality providers creates unnecessary barriers to treatment. Below we further outline the problem and identify solutions:

Increasing levels of burdensome authorizations and denials: Medical staff in several of our accredited addiction treatment facilities across several states are increasingly forced to navigate tremendous administrative hurdles; for instance, they report record levels of Medicaid and commercial insurance denials and prior authorizations for OUD treatment and, in some cases, report being asked to submit upwards of 70 pages of clinical documentation for treatment of *a single patient*. This disconnect between quality and reimbursement has fostered an environment in which predatory MAT prescribers thrive and quality providers – those committed to offering a full continuum of care mirrored after nationally recognized clinical models – are backed into a tight financial corner. This reality causes millions of dollars to be spent on claims management instead of patient care. To safeguard against further abuse, and to incent patient-centered care, Centerstone recommends the following:

- **Tie federal dollars to evidence-based services *only*.** To ensure that patients are truly receiving quality services, and maximize their chances of achieving positive outcomes, we recommend that providers serving Medicaid/Medicare beneficiaries for SUD(s) demonstrate the ability to offer a comprehensive continuum of evidence-based services. Payment models should be linked to standardized outcomes and designed to incentivize integrated, whole-person care models for addictions treatment, particularly for patients with co-occurring and complex conditions.
- **Develop a “gold standard” certification that would establish “clinical excellence hubs”** as preferred providers for courts, corrections, emergency departments, etc. for trusted patient referrals. These clinical excellence hubs would need to demonstrate use of evidence-based interventions, linkages to a full continuum of care, including services geared towards increasing patients’ recovery capital², and report on patient outcomes. To incentivize a move towards this end, excellence hubs could be eligible for federal funds within Medicare and Medicaid upon a showing of successful implementation and reporting on treat-to-target metrics, such as:
 - *Superb Customer Service*
 - This would be measured by the Health Home customer service survey, which asks:
 - “How likely is it that you would recommend (provider’s name) health home to a friend or colleague?”
 - “How confident do you feel managing your condition(s)?”
 - “How connected do you feel to your care team?”
 - *Excellent Access to Care*, as measured by:
 - % clients receiving appropriate level of care engagement intensity
 - % clients who access routine care < 10 days
 - % clients who access urgent care < 3 days
 - *Treat-to-Target Care Process goals*, as measured by:

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2211734/>



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- % of clients whose improvement is tracked
 - % of clients not improving that:
 - receive a significant treatment plan change;
 - are staffed in a treatment team meeting
 - % of clients that experience symptom improvement to ASAM Level I.
 - % of urine analyses which come back free of drugs of abuse. (Note: this outcome measure can assist in drawing a line between MAT pill mills and providers who are appropriately administering MAT.)
- *Treat to Target Care Outcome Goals*, as measured by:
 - Increase Recovery Capital (measured via the Centerstone Recovery Capital assessment)
 - Decreased hospital & ER days
 - Decreased functional impairment
 - Decreased substance use
- **Incentivize value-based, integrated addiction treatment models**³. At Centerstone, we are developing a “Per Member Per Month” (PMPM) model for outpatient treatment within in our *recovery oriented medication assisted treatment (RO-MAT)* framework. This model requires treating the patient holistically, building their recovery capital, and for the majority of our patients, working toward a discontinuation protocol from medication assisted treatment. In all of our models, we include treat-to-target metrics to assess patient progress along the recovery pathway.
 - **Provide for meaningful reimbursement of mobile crisis services.** As a result of the opioid epidemic, requests from hospitals for our mobile crisis services have increased dramatically. Mobile crisis services entail a licensed counselor, case manager, or peer specialist travelling to an emergency department, where an individual typically presents after an overdose, to engage an individual in their recovery. Staff time in transit to and from an emergency department, staff mileage, as well as emergency department engagement services are not typically adjusted for in our reimbursement rates. Fortunately, Centerstone staff in several of our footprint states have recently been able to provide these services thanks to 21st Century Cures STR grants. In Kentucky, for example, our new pilot, which consists of integrating peer supports into the emergency department, has already resulted in a 25% “conversion rate.” This means that 25% of persons arriving at the local emergency departments due to an opioid related overdose are choosing to receive treatment. With our pilot still in its infancy, we believe this rate will increase significantly as we implement improvements to our engagement strategy and workflow. Below is a success story, as explained by one of our clinicians:
 - *“In the first week of operation, we engaged a client who was a high utilizer. He had accessed the Emergency Room over 115 times in the previous year. We were able to provide him direct access into services. He completed detox, transitioned into a halfway house, and finished Intensive Outpatient Programming (IOP). He is now in traditional outpatient programming utilizing peer support services and case management. For the first time in his life, this person is verbalizing hope for recovery, gratitude, and a desire to continue to change his life.”* From a human transformation perspective, this is remarkable. From an expense/utilization reduction perspective, it is also quite compelling.

³ <https://centerstone.org/blog/research-institute/centerstone-integrated-addictions-care-and-our-3-promises>



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Thus, to enable mental health and addiction treatment providers to continue offering these important and life-saving services, mobile crisis services must be reimbursable in a meaningful way. In evaluating financial models that would incent the appropriate use of mobile crisis services in engaging acute patients, we suggest either a bundled payment model, or an enhanced rate/code specific to mobile SUD engagement.

- **Remove barriers to effective uses of telehealth.** According to the National Rural Health Association, 30 million Americans currently live in rural counties where access to addiction treatment services and medications is unavailable⁴. Last week, the *Bipartisan Budget Act*⁵ took steps to facilitate telehealth in Medicare Advantage plans, provide nationwide access to telestroke, and improve access to telehealth-enabled home dialysis therapy.⁶ This is a great step towards removing barriers to the use of telehealth, but the same can be done for telebehavioral health. For example, Congress and the Administration can break down barriers for use of peer support services, delivered via telehealth, in both Medicaid and Medicare. Peer support services are currently accepted as evidence-based practices by both CMS and SAMHSA. Research indicates that use of peer supports leads to significant decreases in substance use, symptom improvement, and better management of patients' own conditions⁷. These outcomes are largely achieved by a sense of trust and by the non-judgmental attitude peers exhibit towards patients.

Therefore, Centerstone recommends that Congress fully optimize the value of our behavioral health workforce by affording certified peer supports the ability to serve patients with substance use disorders (SUDs), within their scope of practice, via telemedicine. The use of certified peer supports should *only* be utilized in the context of a broader continuum of care, *managed by a licensed addiction or mental health specialist*, to ensure appropriate evidence-based treatment planning, intensity, services, and duration for select patients.

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

- **Create a national standard for an interoperable, real time PDMP.** Technology and standards that are available today across the country, in doctors' offices and at pharmacy counters, have the ability to inform, standardize, and enhance the information that is available to clinicians at the points of prescribing and dispensing. Prescription drug monitoring programs (PDMPs) are crucial sources of data for providers; however, PDMPs could have a larger impact in combatting the opioid epidemic if challenges in the current system were addressed. Current challenges include: interoperability among states and with other health IT, real-time data, and information that is in the workflow and user-friendly for providers.
 - **Interoperability:** PDMPs are profoundly different across states and in how they are integrated with health IT in each state. These differences present many challenges, and limit data access to providers at point of care. Improving interoperability of PDMPs will allow

⁴ https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Treating-the-Rural-Opioid-Epidemic_Feb-2017_NRHA-Policy-Paper.pdf

⁵ Bipartisan Budget Act of 2018. Accessed: <https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf>

⁶ <http://thehill.com/opinion/healthcare/373589-congress-just-took-action-on-technology-enabled-medicare-reforms>

⁷ <https://www.ncbi.nlm.nih.gov/pubmed/26882891>



providers the ability to check patient prescription histories, alert providers to individuals with patterns indicative of misuse, and prevent patient doctor shopping.

- **Real-time:** PDMPs currently run on batched information, only being utilized retroactively to track dispensing data for patients. If improvements to the current system are made, prescriptions could be stopped before they are dispensed, or even before the prescription is written. It is at this point that a clinician would have the opportunity to not only stop the medication from potentially falling into the hands of an individual exhibiting addictive behaviors, but to address those potential harmful behaviors and help refer to treatment or alternate therapies. Policies be put in place to mandate real-time reporting, which would allow for providers to make clinical decisions at point-of-care, and make the health care process more uniform, accurate, collaborative, and patient-centered.
- **Within workflow:** In order to check a state’s PDMP, most clinicians are required to log in to a system separate from their normal medical record software (EHR, prescription dispensing system, etc.), query the site, analyze the report results, and then return to their original workflow. In order for PDMPs to have a greater impact, they should be made accessible in existing provider software. These improvements will ensure PDMP data is utilized at point-of-care and that this data can be shared in real-time across the network; thus also reducing prescriber burden.
- **Utilize PDMP’s to link patients to treatment by automating, or incenting, an SBIRT function:** Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based preventative measure designed to move patients, who may need help, into treatment. SBIRT uses tools like Motivational Interviewing to identify those at risk for developing an SUD and help those who already have an SUD. Generally, SBIRT increases an individual’s chance for early intervention and access to treatment. By linking SBIRT functions to a PDMP system, we would not only be able to “flag” at risk patients, but also appropriately screen and refer to treatment.
- **Align 42 CFR Part 2 with HIPAA.** Currently, only federally assisted alcohol and drug abuse programs providing SUD diagnosis or treatment are subject to the stringent Confidentiality of Substance Use Disorder Patient Records rule – 42 CFR Part 2. Part 2 prevents these federally funded providers from accessing a patient’s full substance use history without the patient’s prior written consent. In contrast, private practitioners or providers within for-profit programs providing SUD diagnosis and/or treatment are not automatically subject to this regulation, and may treat SUD-related patient records like any other medical record under HIPAA. A private practitioner who does not use a controlled substance for treatment, such as Naltrexone, for example, is not subject to Part 2. It is crucial for front-line providers to have full access to patient records in order to provide safe patient care. Common sense legislation like *The Protecting Jessica Grubb’s Legacy Act, S. 1850*, co-sponsored by Senators Shelley Moore Capito (R-WV) and Joe Manchin (D-WV), would align Part 2 with HIPAA for the purposes of treatment, payment, and health care operations, and strengthen protections against the use of substance use disorder records in criminal proceedings. Doing so would increase care coordination and integration among treating providers and other entities in communities across the nation.



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Question #7: What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

- **Promote the use of integrated health homes for addiction treatment.** Centerstone has extensive experience implementing patient centered health homes. These health homes are specifically designed to provide integrated, patient-centered care to consumers with co-occurring, complex conditions. Through this model, we have been able to provide contiguous care to consumers who had previously only experienced fragmented, expensive care. Through our health homes, Centerstone has achieved demonstrable outcomes within our patient population: 84% of our patients with high blood pressure saw lower readings after 12 months; recipients also reported a 56% improvement in anxiety levels and a 53% improvement in general health. Participants awarded this model a 98% approval rating.⁸ Health homes can improve patient outcomes at a significant cost savings.
- **Incentivize breakthrough payment models and technology enabled care.** A potentially transformative approach to treating and managing patients with SUD(s) is using technology enabled care, delivered via apps and smart devices directly to the patient. With over 95% of Americans having access to a cell phone, and 80% of Americans having access to a smart device, fully leveraging technologies can quickly advance patient care.^{9 10} Centerstone is now piloting technologies that will make use of evidence-based screeners and engagement tools aimed at increasing patient involvement in developing and adhering to their unique treatment plans. Ultimately, the app will link to bidirectional electronic health records systems that can alert case managers or peers if a patient appears to be at risk of hospitalization, allowing the provider to engage the patient before a higher level of care is needed. We recommend that Congress look into funding streams that will support those identifying and testing new technologies as well as incent further innovation in this space.

We appreciate the opportunity to suggest policy changes the Senate Finance Committee may consider in alleviating the Opioid Crisis. Kindly let us know if you have any questions or comments. We look forward to working with you in the future.

Sincerely,

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⁸ <https://centerstone.org/our-resources/health-wellness/what-is-a-health-home>

⁹ <http://www.pewinternet.org/fact-sheet/mobile/>

¹⁰ <http://www.pewinternet.org/fact-sheet/mobile/>



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