Comment on Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program

The policies enacted by Comprehensive Addiction Recovery Act of 2016 (CARA) and the 21st Century Cures Act are substantial first steps to alleviating the strain the opioid crisis is having on populations throughout the US. This regulation seeks to fully implement the major provisions on these policies. Some approaches to reducing substance abuse include increasing the availability of naloxone and “good Samaritan” laws, developing more medical assisted therapy programs, and drug monitoring mandates on physicians. Each have varying levels of success, but they are addressing the clinical condition of addiction.

The proposed regulation fully implements section 704 of CARA allows sponsors of the Part D plan to establish drug monitoring programs such as a lock in program. The “lock-in” policy requires patients that have been identified as opiate overutilizers to use one pharmacy and one provider or prescriber to get their opioid drugs. Based on CMS data, 76% of beneficiaries could be eligible for being labelled “at-risk” and therefore qualifying them for the lock-in program. While the lock-in programs de reduce the number of opioid prescription claims, there is evidence that is also increases the likelihood of a patient circumventing their locked in pharmacy or prescriber and opting to pay out of pocket for opioids (Health Affairs, 2016). The proposed rule does characterize the lock-in program as a tool to use as a last resort, but for state health systems that don’t have the resources, these tools may be overused in preference to more substantial programs.

Lock-in programs had been largely successful in reducing the number of claims but there has been little analysis as to whether it is actually reducing the prevalence of substance abuse. The purpose of lock-in programs is to prevent patients from overutilizing opioid drugs, an goal that aims to decrease the number of people addicted to opioids. It addresses stakeholder, provider and policy makers concerns about the volume of prescription opioids but it hasn’t been shown to be effective for the beneficiary (Roberts, Gellad and Skinner, 2016). If a patient is already overutilizing opioids, they won’t simply stop because of a policy maneuver. In fact, they may not be ready to confront that they need treatment or even if they know, may still not want it. In the 2014 National Survey of Drug Use and Health, respondents indicated that biggest barriers to opioid treatment is access and lack of readiness. Nearly 39% of participants in the study reported they did not have health insurance for opioid treatment and 29% they were not ready to stop using (Health Affairs Blog, 2016). It speaks to a larger problem of the opioid crisis not simply being about the volume of prescription pain killers.

The Affordable Care Act sought to establish patient-centered medical homes as a way to alleviate the barriers to access and increase patient self-efficacy. By modifying the lock-in program to be less restrictive and refocusing policy on the patient, Medicaid could have a long lasting impact of those suffering from opioid addiction. A treatment specific patient centered medical home, like those that been successful in Maryland, Rhode Island and Vermont, could better deliver the results that policy-makers and stakeholders want from opioid treatment policy (Roberts et al., 2016). These treatment specific medical homes provide coordination for the patient to have care from both their medical and behavioral health providers and ensure that they can address comorbid problems. The Medicaid population is known for comorbidity of mental illness and chronic non-cancer pain. In the study conducted by Roberts et al., of the Medicaid patients who were in the lock-in program, 58% had diagnosed anxiety disorder and 55% had diagnosed depression. The authors indicated that this is not unusual for the Medicaid population, so policies must not ignore the comorbid aspect of treating chronic pain. This proposed rule may be the one to encourage and create incentives for sponsors to establish treatment specific medical homes, but it should be a call for CMS to truly evaluate the effectiveness of lock in programs.

The declaration of a public health emergency created an opportunity for Medicaid to encourage innovative strategies that would help patients suffering from opioid addiction. The lock-in programs have been established since 1970, and there hasn’t been strong evidence or assessments, that its actually helping the patients. Instead, it’s just showing that Medicaid isn’t reimbursing for as many pain killers. The ultimate goal of creating policy to address the opioid crisis should be to increase the number of people receiving treatment, the number of people receiving alternatives to opiates, and decreasing the number of people addicted overall.

**References**

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