

**PREVENTING AND TREATING OPIOID MISUSE  
AMONG OLDER AMERICANS**

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**HEARING**  
BEFORE THE  
**SPECIAL COMMITTEE ON AGING**  
**UNITED STATES SENATE**  
ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

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## **PREVENTING AND TREATING OPIOID MISUSE AMONG OLDER AMERICANS**

**WEDNESDAY, MAY 23, 2018**

U.S. SENATE,  
SPECIAL COMMITTEE ON AGING,  
*Washington, DC.*

The Committee met, pursuant to notice, at 1:59 p.m., in room SD-562, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairman of the Committee, presiding.

Present: Senators Collins, Casey, Gillibrand, Blumenthal, Donnelly, and Cortez Masto.

### **OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN**

The CHAIRMAN. The hearing will come to order.

Good afternoon. First, let me thank our witnesses for rearranging their schedules this afternoon to be here even earlier than we had anticipated. We are going to have a series of votes beginning at 3:15, so we wanted to move up the time of the hearing.

Last year, the Portland Press Herald ran an in-depth series titled “Lost,” which told the stories of Mainers who had been most affected by the opioid epidemic. The stories highlighted and exposed many, often unseen, facets of this crisis. It made clear that no one is immune from the devastating effects of addiction.

Dr. Mary Dowd, who specializes in addiction treatment and sees hundreds of patients through her work at Catholic Charities Maine, told the newspaper, “I still think people have this idea in their head about who is caught up in this crisis. It could be anyone.”

Many perceive the face of opioid addiction as young. Indeed, I met this very morning with a substantial group of young people from Maine called Young People in Recovery who were representing young adults from our state who are in recovery or working with those who are seeking to be part of the recovery community.

This epidemic, however, intersects just as much with older adults, something that I think has not received the focus that it deserves. According to the Inspector General, one in three Medicare Part D beneficiaries received an opioid prescription in 2016. The Centers for Disease Control estimates that the number of people age 55 or older treated in emergency rooms for opioid overdoses increased by nearly a third from 2016 to 2017.

Treating pain effectively in an environment where abuse of prescription painkillers is rampant remains a concern for clinicians.

Nearly half of older Americans suffer from chronic pain, and the incidence increases with age.

In addition to the risk of addiction, older adults taking opioids are also four to five times more likely to fall than those taking non-steroidal, anti-inflammatory drugs.

Regrettably, health care providers sometimes miss substance abuse among older adults, as the symptoms can be similar to depression or dementia.

Alternatives to opioids are critical, yet those alternatives may also be more expensive and less convenient for patients. For example, physical therapy can benefit patients suffering from pain, support long-term recovery, and stave off the need for medication, yet patients who work may not have the flexibility to leave their jobs for regular physical therapy appointments. Repeated travel can also be a substantial hurdle for some patients, particularly during the winter months or when a medical condition makes driving unsafe.

Challenges in treatment and recovery persist as well. Seniors in need of treatment may face serious obstacles to accessing care due to a shortage of geriatric health professionals as well as behavioral health care professionals.

In rural areas, those obstacles may be worsened. While there is no silver bullet to ending this epidemic, Congress and this Committee are fighting back on multiple fronts. Since our hearing on opioid use and abuse two years ago, we have made progress in how health care providers discuss pain with their hospitalized patients. At that hearing, I questioned whether hospital performance surveys could be contributing to the vast supply of prescription opioids in circulation by penalizing hospitals if physicians, in their best medical judgment, opted to limit opioid pain relievers to certain patients.

CMS concurred, and since last January, surveys are now asking patients three questions that address communication about pain during their hospital stay, rather than pain management. For example, patients used to be asked a question that I really thought was egregious. It was "How often did the hospital staff do everything they could to help you with your pain?" Now patients are being asked "How often did hospital staff talk with you about how to treat your pain?" Big difference.

Since our hearing, Congress also passed the Comprehensive Addiction and Recovery Act, or CARA, as well as the 21st Century Cures Act, and the recent budget agreement contained \$6 billion to address the opioid crisis.

Last year, HHS issued more than \$800 million in grants to support access to opioid-related treatment, prevention, and recovery, while making it easier for states to receive waivers to cover treatment through their Medicaid programs.

I remain concerned, however, that at least in some areas, it is taking far too long for those funds to reach local health care providers, treatment and recovery organizations, and groups and schools involved with prevention and education efforts.

I have authored two bills to further address this epidemic that have been included in the recent HELP Committee opioids package. The Safe Disposal of Unused Medication Act would authorize

certain hospice employees to dispose of controlled substances in a patient's residence after the hospice patient dies. This would reduce the dangerous risk of diversion of unused painkillers.

Another bill, the Opioid Peer Support Networks Act, would authorize grants to support the creation of peer support networks and create a national technical assistance center to provide the resources and training to help them be successful.

Through these networks, those battling addiction support one another on the road to long-term recovery. So this bill addresses a gap in recovery care since, currently, an estimated 40 to 60 percent of recovering addicts relapse.

And just last week, the FDA approved the first non-opioid treatment for the management of opioid withdrawal symptoms in adults. Greater innovation in this area as well as the development of more non-opioid painkillers is crucial, and I commend FDA Commissioner Gottlieb for his leadership.

While all of these steps represent progress, we must continue to reexamine this issue from every angle, as the opioid crisis continues to tighten its grip not only on older adults, but also on future generations.

I now look forward to hearing from our witnesses, but first, I turn to our Ranking Member, Senator Casey, for his opening statement.

Thank you, Senator.

**OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR.,  
RANKING MEMBER**

Senator CASEY. Thank you, Madam Chairman, for holding this hearing today on this critically important topic.

When I ask the people of Pennsylvania how opioids affect their families, I am met with—and I know this goes for every Senator who goes home to talk about these issues. I am met with one too many harrowing stories, over and over again, story after story.

One of the worst stories, probably the worst story or the most telling metric unfortunately, was something that a coroner in one of our counties said to me last summer, back in August, when we went around the state, county after county, dealing with this horror. He told me that because of opioid overdoses, he had run out of places to put the bodies. Too many bodies were coming in every night, and there was no place to put them, literally running out of space. More than any other story, this one underscores the urgent need for Congress to continue to take aggressive action.

The opioid epidemic is ravaging our communities, and I am not sure that adequately describes it. It is in every corner of our country, from small, rural towns to bustling city centers and even to suburbs. It affects people of all ages, from tiny little babies to aging grandparents.

Recently, "60 Minutes" told the story of how grandparents across the country are "saving a generation" by stepping up to raise their grandchildren. I think that is why we have a responsibility to save these multiple generations.

That is why I introduced legislation to provide \$45 billion in federal support to support community programs to detect, prevent, and treat opioid misuse, and that is why I am working with Chair-

man Collins to make sure that grandparents raising their grandchildren, whose parents are lost to opioids, know where to turn for both education and support.

It is also why I have been working on a bipartisan basis with Leader McConnell to create a federal plan to provide opioid treatment for infants as well as to pregnant and postpartum women.

And I have also worked with Senator Portman so that older Americans and people with disabilities have Medicare coverage for the opioid treatment that is right for them.

I was pleased to join Democrats and Republicans in providing \$6 billion to states to fund prevention, treatment, and recovery efforts over the next two years, but I know that is not enough. Nearly 13 Pennsylvanians are lost every day due to a drug overdose, beyond the opioid issue but substance use disorder overall.

We have to do more for every generation, and we have to do it now.

Older Americans are among those unseen in this epidemic. In 2016, one in three people with a Medicare prescription drug plan received an opioid prescription. This puts baby boomers and our oldest generation at great risk.

More than 1,400 older adults lost their lives to opioids in 2016—1,400 people—despite the availability of life-saving medications that reverse overdose. These startling facts beg the question: What more should we be doing? What barriers prevent older Americans from accessing treatment? What more can Congress do to ensure that not one more senior goes without recovery services?

For instance, I am exploring how to make opioid treatment more affordable. A high copayment should not stand between a senior who needs treatment and their access to care.

It is time for bold and bipartisan leadership to address the wreckage of this dreadful epidemic. Indeed, this hearing is an important step in doing just that, and I want to thank Chairman Collins again and look forward to our witnesses' testimony.

The CHAIRMAN. Thank you very much, Senator Casey.

I am pleased to introduce our witnesses. Our first witness is Gary Cantrell, the Deputy Inspector General for Investigations at the Department of Health and Human Services, Office of the Inspector General.

Mr. Cantrell will provide an overview of the Office of Inspector General's report, "Opioids in Medicare Part D: Concerns About Extreme Use and Questionable Prescribing."

Next, I am delighted to introduce Dr. Charles Pattavina, the Medical Director and Chief of Emergency Medicine at St. Joseph Hospital in Bangor, Maine. He is also former president of the Maine Medical Association. Dr. Pattavina has extensive experience treating patients in the State of Maine, including adults living with debilitating chronic pain. And I want to thank you personally for taking the time of what I know firsthand is a very busy schedule serving patients.

I will now turn to our Ranking Member to introduce our witness from the Commonwealth of Pennsylvania.

Senator CASEY. Thank you, Madam Chairman.

I am pleased to introduce William Stauffer, who is a lifelong Pennsylvanian and resident of Allentown in the Lehigh Valley on



the eastern side of our state, and I know we have met before along the road, but I did not have a chance to personally welcome you to the hearing today. I was running late. So thanks for being here.

Mr. Stauffer's organization, the Pennsylvania Recovery Organizations Alliance, represents community-based groups, family support programs, and advocates across the state working tirelessly to promote treatment for substance use disorders. He has more than 25 years' experience offering counseling and administrative support to recovery programs. He brings a very personal lens to our hearing today, as he is in long-term recovery.

Mr. Stauffer, as a social worker, I am especially proud to have you here today for that and many reasons. The social work profession is near to my heart. My daughter is a social worker. I know what you bring to your work and what it means to so many. We are fortunate to have your perspective today both as a recovery professional as well as a person living with an addiction.

Thank you again for being here. We look forward to your testimony.

The CHAIRMAN. Mr. Terry, I know that Senator Donnelly very much wants to introduce you and that he is on his way. So I am going to turn to Mr. Cantrell for his testimony, and it is not that you are being neglected. It is that your home state Senator is very proud of you and wants to introduce you personally.

So, Mr. Cantrell.

**STATEMENT OF GARY CANTRELL, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. CANTRELL. Good afternoon, Chairman Collins, Ranking Member Casey, and Senators Cortez Masto and Senator Blumenthal. I appreciate the opportunity to be here today to speak with you about OIG's efforts to combat the opioid epidemic in federal health care programs.

Given our long history of health care fraud enforcement, program oversight, and data analytic capabilities, OIG is uniquely positioned to help lead the fight against illegal opioid prescribing in Medicare and Medicaid, and we are also intent on using our resources to assist HHS in delivering quality treatment services to those in need.

Opioid-related fraud encompasses a broad range of criminal activity, from prescription drug diversion to addiction treatment fraud. Many of these schemes involve kickbacks, medical identity theft, and criminal enterprises. The development of our investigations into these schemes is complex, requiring the full range of law enforcement techniques to gather evidence of crimes, often committed by corrupt doctors, pharmacists, and criminal networks.

In the worst cases, our special agents have uncovered evidence of illegal prescribing resulting in deaths from overdose.

Given the complexity and high stakes of these investigations, OIG's partnership with DOJ, FBI, DEA, and state Medicaid fraud control agencies are critical to the success of our efforts.

OIG and our Medicare Fraud Strike Force partners led the 2017 National Health Care Fraud Takedown. This enforcement operation brought together more than 1,000 federal and state law en-

forcement personnel, including 350 OIG special agents. The 2017 takedown was the largest health care fraud enforcement action ever, resulting in over 400 charged defendants across the country. 120 of these defendants were charged for their roles in illegally prescribing opioids and other dangerous narcotics.

OIG has also shifted resources to support the Attorney General's Opioid Fraud and Abuse Detection Unit, a multi-agency effort capitalizing on data analytics. Prosecutors and agents currently operate in 12 districts and focus solely on investigating and prosecuting opioid-related health care fraud.

OIG uses advanced data analytics to put timely actionable information about prescribing, billing, and utilization trends in the hands of investigators, auditors, evaluators, and our government partners.

Our July 2017 data brief identified Medicare beneficiaries receiving extremely high amounts of opioids, and questionable prescribing demonstrates the value of this approach. Of note, the report uncovered that half a million Medicare beneficiaries received opioids well in excess of CDC guidelines. Of particular interest to this Committee, 36 percent of these beneficiaries were age 65 or older.

Further, nearly 90,00 beneficiaries are at serious risk of opioid misuse or overdose. Some received extreme amounts of opioids, over two and a half times the CDC guidelines, while others appeared to be doctor shopping, and 23 percent of these beneficiaries were age 65 or older.

To get at the source of this extreme use, OIG identified about 400 prescribers, with questionable opioid prescribing for these beneficiaries who are at serious risk, and we are following up on these outlier prescribers and have also shared this data with our public-and private-sector partners.

OIG will also release an update to this data brief later this summer based on more recent claims data. This update will help us monitor trends in opioid prescribing and direct our resources where most needed.

In conjunction with the new data brief, OIG will also release an analysis toolkit based on the methodology OIG has developed in our extensive work on opioids to assist our public and private sector partners with analyzing their own prescription drug claims data to help combat the opioid crisis. This is an example of how we leverage our relationships and empower our partners to help us tackle this problem.

OIG has also initiated work beyond Medicare. The work identifies opportunities to strengthen program integrity and protect at-risk beneficiaries across multiple HHS programs. For example, OIG audits and evaluations currently under way address a broad range of opioid-related funding and activity at HHS, including opioid prescribing in Medicaid, grants for prescription drug monitoring programs, FDA's opioid risk management program, and whether those in most need have access to medication-assisted treatment.

In summary, OIG will continue to hold criminals accountable, and our work will result in impactful recommendations to improve program integrity, save taxpayer dollars, protect HHS beneficiaries from harm, and improve the quality and accessibility of treatment.

Thank you, and I look forward to answering your questions.  
 The CHAIRMAN. Thank you very much.  
 Dr. Pattavina.

**STATEMENT OF CHARLES PATTAVINA, M.D., FACEP, MEDICAL  
 DIRECTOR AND CHIEF OF EMERGENCY MEDICINE, ST. JOSEPH  
 HOSPITAL, BANGOR, MAINE**

Dr. PATTAVINA. Thank you, Chairman Collins and Ranking Member Casey, and good afternoon.

The Senator gave a nice introduction earlier, but I should say I recently decided to take on a new role, which is Medical Director and Chief of Emergency Medicine at St. Joe's. I have been promoted to full-time patient care and work for the people I hired, and I am the immediate past president of the Maine Medical Association, and I served on the Board of the American College of Emergency Physicians from 1997 to 2003. I really appreciate the opportunity to speak to you today about the impact this terrible crisis is having on older Americans.

Now, as you know, it claims the lives of almost 120 Americans a day and about one a day in my State of Maine, and sadly, the number went up from 2016 to 2017 from 365 to 400, just as we thought we were turning the corner.

And as the Chairman mentioned earlier, recent CDC data show an increase of about a third in opioid overdose emergency department visits by Americans over the age of 55 over a period that was barely more than a year, so we know this is a very serious problem.

And also, I heard from the CDC this morning that the opioid epidemic is having a measurable negative impact on the life expectancy of Americans.

While the effects of the opioid epidemic on seniors are similar to the effects on the population as a whole, it does present some unique challenges for older Americans. As we know, most people who are now addicted did start on prescription pain medications, although they were not necessarily prescribed for them. In many cases, they were obtained through illicit channels.

We are seeing many cases in which people have become dependent on these medications and are tapered off them too quickly or even abruptly, and this creates problems.

One of the problems we do have in treating people's pain, at least in conventional methods with medications, is that the choices are limited. There are the nonsteroidals, which the Chairman mentioned, that cannot be given to some people of any age, but particularly older people because of damaged kidney function or other illnesses that tend to be more common in older people. And there is Tylenol and pretty much everything else that is a prescription, but there are some things that are getting more use, such as lidocaine patches, and there are a number of other opportunities.

But in terms of opioids, it is difficult in older people because of the existence of comorbidity. Certainly, the longer a person lives, the more likely they are to have more medical problems, and the effects of the drugs, especially in combination with others, can be magnified in this group, whether it is drowsiness, confusion, falls, as has been mentioned.

I found the data brief very interesting and appalling, frankly. It is clear there is a very serious problem with outlier prescribers. A very small number of prescribers are writing for a very large number of opioids for a very small number of beneficiaries, and I appreciate the efforts you are taking to combat that problem.

Regarding the prescription monitoring Web site, that has improved. Interestingly, even in spite of your efforts to require it, I believe I am still not seeing prescriptions from the Veterans Administration in the Maine PMP, and that is a problem.

Patient perception of pain is a real challenge, particularly among those who have been on opioids for a long time. I am sure you hear from those people as well, and it is just an indication that great care and time must be taken to taper anyone's dose, so that people do not go outside the system seeking pain medication.

And as was mentioned, there are a lot of great innovations and ideas out there that are coming forth from this terrible problem.

We certainly do have a lot more resources than we had just a year ago, and the limits on prescribing Suboxone have been increased, as was mentioned, and I appreciate that. We can talk about that some more, but some action needs to be taken. We need more people willing to prescribe it, particularly in primary care.

I am happy to say we do have some more resources in Bangor than we used to have. We have a social detox center funded by a state grant, and I will be happy to talk about anything else in the question session, but I appreciate the opportunity to be here today and help. Thanks.

The CHAIRMAN. Thank you very much.  
Mr. Stauffer.

**STATEMENT OF WILLIAM STAUFFER, EXECUTIVE DIRECTOR,  
PENNSYLVANIA RECOVERY ORGANIZATIONS ALLIANCE**

Mr. STAUFFER. First, I would like to thank Chairman Collins and Ranking Member Casey and other members of this Committee for hosting this important hearing and having the opportunity to testify on this critically important issue to the United States.

My name is William Stauffer. I am a person in long-term recovery, continuous recovery, and for that, what that means to me is that I have not used drugs and alcohol for over 31 years. I think it is relevant to note to this Committee that I received treatment with public dollars, and that investment in my life made all the difference in the world. It has allowed me to be a responsible member in my own community.

My recovery has allowed me to earn a college degree, to own a home, to be a good husband, to volunteer in my community, to pay taxes, to be a college professor, and become an advocate for the recovery community in the great State of Pennsylvania.

The most remarkable thing about my kind of story is that it is quite common in the recovery community. We can do great things in recovery, no matter what age we start our journeys.

I too will turn age 65 one day, and I hope that I and all those like me will have a full array of recovery support services and treatment options available to me and to other people in our community that may need them.

Congress should work to ensure that this is the case, particularly as we have 10,000 baby boomers turning 65 every day in the United States.

My written and oral testimony here today are as a result of my experience in recovery as well as my professional experience across three decades of service to our community.

I run PRO-A, the statewide recovery organization. I have operated residential treatment facilities. I have operated outpatient counseling facilities, and I currently work as a professor of Social Work at Misericordia University, where I wrote a course on substance use and older adults.

As was noted in the opening remarks, one in three Americans with Medicare coverage are prescribed opioid painkillers; however, while Medicare pays for opioid painkillers, Medicare does not pay for drug and alcohol treatment in most instances, nor does it pay for all the medications that are used to help people in the treatment and recovery process.

Methadone specifically is a medication that is not covered by Medicare to treat opioid use conditions. It is important to note that the recovery community supports the use of medication as part of the treatment and recovery process. We strongly believe in multiple pathways to recovery. We understand that medications are important elements in the treatment and recovery process for adults seeking help with an opioid dependency, including for older adults. Recovery with medication is a reality for members of our community, as are other pathways.

This Committee is showing true leaderships for focusing on the needs of older adults. We know full well that substance use conditions impact Americans of all age groups; however, the needs of older adults who have experienced a substance use condition get too often missed or ignored. The topic receives scant attention in the literature or training for medical professionals. There are few places to refer to who specialize in older adult care. Providers who want to meet these needs often cannot, as reimbursement rates are far too low.

Older adults who have a problem face a triumvirate of stigma. Far too often family members, caregivers, and physicians fail to see, ignore, or underestimate the extent of the need for help.

It is important to note that a long-term area of concern is the Institute of Mental Disorders exclusion, where costs get shifted to the Substance Use Prevention and Treatment block grant. Fixing this issue would help states have resources for older adults. The IMD exclusion has long been a barrier for treatment.

We are deeply grateful to Senator Casey for his many years of support in efforts to get rid of the IMD exclusion. We are also grateful to Chairman Collins, who supports the elimination of the IMD exclusion. We urge you to remove drugs and alcohol from the IMD exclusion as the Road to Recovery Act would do. This will allow older adults' service to be paid for out of the Substance Use Prevention and Treatment block grant instead of diverting resources from the IMD.

We applaud Senator Casey for his bill that would have Medicare pay for methadone. We would take additional steps to ensure that people are treated properly and that when an older adult has a

substance use disorder that their needs are met in a full continuum of services.

We applaud efforts being made in Congress to expand medication-assisted treatment to Americans 65 and older, and we know that this is a fast-growing area of need.

We must expand education to physicians and other practitioners so that the unique challenges of older adults are met, and we must provide sufficient resources to make sure that services are available.

I want to thank all of you for this opportunity to shed light on this important issue. I think this is just a start. I think we have to have more hearings to make sure that needs are met for older adult Americans. Thank you.

The CHAIRMAN. Thank you very much for your testimony, and congratulations. That is an impressive story.

Mr. STAUFFER. You mentioned YPR. I currently refer to myself as a formerly young person still in recovery.

Thank you.

The CHAIRMAN. Thank you.

Professor Terry, it looks like you are stuck with me as the introducer. I will introduce you as a professor of law and executive director of The William S. and Christine S. Hall Center for Law and Health at Indiana University. Professor Terry is the author of a book or a co-author of a report titled "Legal and Policy Best Practices in Response to the Opioid Epidemic," and would not you know?

[Laughter.]

The CHAIRMAN. I just introduced your witness, but you are welcome to add something to it since—

Senator DONNELLY. I will add an extra word, which is thank you, Chairman Collins, for also introducing—

The CHAIRMAN. There you go.

Senator DONNELLY [continuing]. Nic Terry from Indiana University.

Mr. Terry is a professor of law and executive director of the Hall Center for Law and Health and IU Law School. He recently helped lead a team of researchers in creating a report titled "Legal and Policy Best Practices in Response to the Substance Abuse Crisis." This research was conducted as part of IU's \$50 million Grand Challenge Initiative to address the opioid epidemic in Indiana.

This has been a heartbreaking challenge. We have lost so many young people who could have been the next nurse, the next teacher, the next policeman, and I know we are all in this together to beat this.

And, Mr. Terry, we are thrilled that you are here. Thank you.

**STATEMENT OF NICOLAS P. TERRY, PROFESSOR OF LAW AND EXECUTIVE DIRECTOR OF THE WILLIAM S. AND CHRISTINE S. HALL CENTER FOR LAW AND HEALTH, INDIANA UNIVERSITY**

Mr. TERRY. Thank you for both introductions.

Senator DONNELLY. Hers was probably better.

[Laughter.]

Mr. TERRY. Thank you, Chairman Collins, Ranking Member Casey, and Committee members for this opportunity.

In our research, we noted positive steps taken in our state and elsewhere, such as various supply side approaches to reducing the number of opioids in circulation. While perfection can be the enemy of the good, sometimes good is not good enough.

We concluded that we could do much more, specifically prioritize harm reduction such as by supporting the work of syringe exchange programs, creating more safe spaces, and reducing stigma; by removing legal impediments that hold up effective responses, such as by better coordinating federal privacy laws; and make careful and sustaining investments in health care services to provide more and improved evidence-based treatment.

There are several complicating factors involving opioid use in the elderly. Because of chronic pain, the near-elderly and elderly likely will be longer-term users of opioids. Medication sensitivity increases with age. Polypharmacy heightens risk associated with SUD. Drug hoarding and drug sharing are common. Comorbidities increase the risk of missing an OUD diagnosis.

Indeed, opioid use has been associated with fall-related injuries and death among older adults. Risks of injury and death are substantially higher among older adults with opioid use disorder, and rural older adults are dying from the opioid epidemic at a slightly higher rate than older adults generally.

Many of the aspects of this crisis apply equally to seniors and juniors, but some specific complicating considerations also come into play.

First, care coordination challenges. Persons suffering from SUD and frequent comorbidities such as mental health diseases are particularly vulnerable populations that in practice require additional and particularly robust levels of care coordination. These unmet needs likely are exacerbated when we combine additional comorbidities associated with the near-elderly and elderly.

Hospital readmissions among the elderly are a useful proxy, with a higher rate of readmission among seniors with multiple symptoms, such as cognitive impairment and polypharmacy. Indeed, the readmissions penalty program is an attempt to make hospitals commit to wraparound services, including home visits to assist vulnerable populations.

The best-known case management, care coordination, and wrap-around services model is that adopted by the Ryan White HIV/AIDS Program. By filling gaps between existing programs and services and because it is a payer of last resort, the program has been extremely successful in reducing AIDS-related mortality and morbidity. It is a thoughtful model to follow anytime we examine health care services for vulnerable populations.

Second, access. Access issues will remain with long waiting lists, limited treatment availability in some rural areas, and quality issues caused, for example, by facilities being detox-only or not offering a full range of evidence-based medication-assisted treatments.

Approximately 23 percent of the Medicaid population are over 45 years of age. We know that CMS is highly supportive of state flexibility in Medicaid services, and states are leveraging Section 1115

waiver authority to test innovations. However, some recently approved waivers, such as paperwork requirements for establishing eligibility and premium payments, may disproportionately affect persons with SUD and comorbidities.

More positively, Section 1115 waivers may be available to implement innovations in behavioral health such as suspending the IMD exclusion, reimbursing care coordination, or paying for services that address health-related social needs such as supportive housing, transportation, and food.

Finally, undertreatment. One of the frequent calls to action during the opioid crisis is to reduce overprescribing and overtreatment. However, as overtreatment is brought under control, the pendulum may swing too far in the other direction.

According to SAMHSA, nearly half of older Americans suffer from a chronic pain disorder, and the instance of chronic pain increases with age. Even today, pain among older adults is largely undertreated.

Denying prescription opioids to a cohort that suffers from chronic pain and in the case of the elderly or near-elderly has been treated for a decade or more with opioids could have serious consequences, undertreatment and the possibility of that cohort turning to illegal drugs.

In preparing these remarks, we found gaps in the data and relatively little evidence-based research discussing opioid misuse among elderly cohorts, suggesting that additional research is warranted.

Once again, I express my thanks to the Committee for this opportunity. Going forward, I and other members of the Indiana University Grand Challenge team will be at your disposal.

The CHAIRMAN. Thank you very much, Mr. Terry. I think you have raised an awfully good point about the pendulum swinging back and forth.

I remember 15 years ago being at a hearing when we were talking about the undertreatment of pain, and now we are in a situation where we have gone the opposite way. And we have to somehow figure this out.

Mr. Cantrell, in your testimony, you referenced doctor shopping as being a problem, and I was surprised to hear that because most states have adopted prescription drug monitoring data bases. And I am wondering if this is an issue where prescribers are not checking the data base or whether the data base does not have current data or whether fraud is involved. Tell us a little bit more about how it is possible for doctor shopping still to exist.

Mr. CANTRELL. Well, thankfully, it was the smallest number of beneficiaries, around 20,000 who were doctor shopping seeing four or more pharmacists or four or more doctors.

I think there are a number of reasons. This is 2016 data. We continue to see improvement in prescription drug monitoring programs, but we know that they are not deployed consistently across the country, that some require checking in more real time and some do not. Some provide greater access to other entities, to review that, to monitor for doctor shopping or overprescribing. So I think it is maybe a product of fraud potentially, and also a product of inconsistent utilization of PDMP data.



The CHAIRMAN. Thank you.

Dr. Pattavina, in your testimony, you mentioned the challenges around patient perception of pain—and we do all have different thresholds in experiencing pain—and the danger that patients or their family members might seek out street drugs if they feel that their pain is not being adequately addressed, and obviously, that puts an individual at much greater risk for an overdose.

Can you describe or are you aware of any specific situations where that has occurred?

Dr. PATTAVINA. Yes, I can. Thank you for that question, Senator.

Yes. As you indicated, in my experience, it is clear that some people suffer more from their suffering or from their pain than others do, and when working with these people, it is important to have a compassionate and kind discussion with them because that is really the cornerstone of any interaction we have, including helping them understand, but that for the most part, these medications, the opioid medications are for short-term pain relief. And one can go over some of the initiatives and innovations that are out there.

In terms of a specific incident, I was informed of a specific incident in which an older woman was in a nursing home, and it was known to the staff that her family felt her pain was being under-treated. And the nurses actually found the patient to have the signs and symptoms of an overdose, and treated her with Narcan. She started to breathe again, and she was taken to the hospital. And it is their strong suspicion that she was given some kind of street drug by the family.

The CHAIRMAN. What do you believe is the most effective way for us to educate patients and their families who are distrustful of plans that involve tapering the use of opioids?

Dr. PATTAVINA. That is a challenge because so often they are afraid.

The CHAIRMAN. Exactly. They are going to be fearful that the pain is going to come back, I would think.

Dr. PATTAVINA. Right. And what has really happened, of course, is they have developed a tolerance to the medication. So they are really not any better off now than they were before they were on the medication, but that explanation only goes so far.

I have long felt that we need to do a better job of highlighting the success stories because there are people who have come off them who feel a lot better, but somehow we need to connect those people with each other, perhaps just doing a better job of publicizing it, because people can have a better life off these medications.

The CHAIRMAN. Thank you.

Senator Casey.

Senator CASEY. Thank you, Madam Chair.

I want to start with Mr. Stauffer, not just because he is from Pennsylvania, but that helps.

We know that experts, including the President's Opioid Commission, note that "complex" policies create barriers for seniors and people with disabilities who are in fact seeking treatment. This includes coverage rules under Medicare that limit patient access to outpatient treatment programs.

In your testimony, you indicate that medications, including methadone, are important elements in the treatment and recovery process for adults seeking help with an opioid dependency, including older adults. Could you explain why expanding Medicare coverage to include methadone would make a difference to the clients you serve and older adults across the country?

Mr. STAUFFER. Yes. Thank you for the question.

What we are seeing is we also have individuals who are currently receiving methadone who when they turn 65, it becomes a challenge to pay for it. That is one group of individuals who this would be applicable to.

We need to think about having all options available to people seeking help with a substance use condition, so having every tool in the toolbox available, and we are in the middle of—I would call it an addiction epidemic because we narrow it down to opioids. Older adults, really we also have to be concerned about alcohol. So we want to make sure that we have all the tools available for clinicians to make good decisions about the care that they are providing.

I would want to note that we want to have great care in how methadone is used for older adults for a lot of the reasons that were identified in this gentleman's testimony about the effects of medications on older adults. We want to make sure that their tolerance for it and their ability to eliminate it from their bodies, because that changes with age. We want to think about things like that as well as multiple drug interactions. Those are things that are important.

But I think having all things available in a continuum of care is critically important as we move forward. I would suggest that we are asking the wrong question when we come to serving people with substance use disorders. We know that in America that people who achieve five years of recovery have about an 85 percent chance of staying in recovery for the rest of their lives. We should be formulating our systems of care around making sure that individuals get those services so that they can get the five years. Things like treatment, peer support services, and things like that would be very important for that, those needs.

Thank you.

Senator CASEY. I know that we hear a lot about naloxone all across the country, sometimes known as Narcan, and the life-saving potential of it, and we should applaud those efforts by states, including states like Pennsylvania that ensure that people can have access to this kind of life-saving treatment without a prescription.

But we should do more because naloxone should be in the hands of every person who might need it. For instance, a high deductible or a copayment should not stand in someone's way.

So I wanted to start with two questions, one for Dr. Pattavina. What are the common barriers that prevent people from receiving naloxone, and what more should Congress do to be breaking down those barriers?

Dr. PATTAVINA. Well, Senator, thanks for that question.

One huge barrier is that it is often available only by prescription, and a lot of us think that it really ought to just be available over

the counter. That would remove a number of complications and difficulties in getting it.

It is about as harmless as a medication could be, really. There is not much you can do with it. So we think over the counter would be one.

The other thing is the cost. Insurance coverage is a little variable, but it can be actually very expensive, I think even up to \$200, if someone without insurance has to actually buy it, so the drug price is also an issue.

Senator CASEY. And I only have about 30 seconds, but, Mr. Stauffer, your experience in our home state?

Mr. STAUFFER. Yes. I would characterize Narcan as the equivalent of giving somebody who is having a heart problem, just reversing and putting their rhythm back in place. It is not like a treatment. It is like saving the life immediately.

You know, I have had the opportunity to meet a librarian from Philadelphia that has saved a half dozen lives.

Senator CASEY. Yep.

Mr. STAUFFER. I am hearing of—there is a gallery, an art gallery, where the artists have saved a number of lives. I carry it. I could not agree with you more that we need to reduce copays and expense of this. It should be available to everyone. We should make it available to anybody who goes to treatment for any substance use condition, their families. We should make it as available to the general public as is possible, so that everyone has an opportunity to reverse an overdose.

Thank you.

Senator CASEY. Thanks very much.

Thank you, Madam Chair.

The CHAIRMAN. Thank you.

Senator Cortez Masto.

Senator CORTEZ MASTO. Thank you. And let me just say thank you again for an incredibly compelling and necessary conversation today. I do not think opioid abuse is immune in any community. Everybody is affected by it, including in the State of Nevada.

A couple of things that—and we have been working on this for a number of years because we have a similar statistic, unfortunately, in Clark County where 70 percent of the population lives. The number one cause of death is overdose, the statistics that we got from our coroner as well, and this was so enlightening a couple of years ago when we saw the trajectory and what was happening here.

So let me pose this because what I have found after working in substance abuse treatment for a number of years are three pillars: education awareness, intervention treatment, enforcement. There has to be a bridge between all of those, and they have to work together.

The challenge that I have found literally is on this treatment side and enough dollars for treatment, but also the type of treatment. Unfortunately, in the work that I have done in the past, what I have seen is for anybody in the State of Nevada, at that time to get any type of treatment, had to commit a crime because there were not enough treatment providers, and you could not voluntarily go and afford it. That is horrific to me, and I think that

is still happening. So it is something we have to address and tear down those barriers so people have access voluntarily to get the treatment they need without having to commit some sort of crime.

With that said, I am curious, and I am going to open it up, and maybe, Mr. Terry, start with you. You talked about some of those barriers. Are there additional barriers that we should be looking at here at the federal level to tear down to make sure people have access to treatment?

And then let me also say the treatment is key. Whether it is evidence-based—or you are the providers. You know better, Dr. Pattavina and Mr. Stauffer, that at the same time, we know there are fraudulent programs out there. And that is why my colleague and I—Senator Moore Capito—introduced legislation to be able to go after those fraudulent programs that are out there that claim to provide some sort of treatment for opioid abuse.

But can you talk about how we tear down the barriers, but how do we ensure as we tear down those barriers that our loved ones are getting to the necessary treatment they need and the type of treatment, and how do we steer them toward it? How do we know? How does a loved one know? How does an individual know the right treatment that is available for them?

And maybe I will just open it up and start with you, Mr. Terry.

Mr. TERRY. Well, thank you, Senator.

I think you can hit that just at a very high level or a very low practical level. Let us start with the second of those.

You have to see this as a care continuum, and we have to take a broader view of what the care continuum is here. That when someone goes down and is rescued by an naloxone shot from EMS or law enforcement, that is not the end of it.

Senator CORTEZ MASTO. Right.

Mr. TERRY. It needs to be the beginning of getting that person to treatment.

When someone walks into a syringe exchange and they start trusting the people there, then that has to be the beginning of getting them moving toward treatment.

When people do not trust law enforcement or they are in areas where there are not good facilities, we need to think about more and better safe places. There are some wonderful examples, almost romantic examples from around the country of firehouses opening up and becoming safe spaces, again, with movement on to treatment.

When people go into an emergency room, there should be a way from there for a referral for peer help and move them into treatment.

To go back to my 5,000-feet observation, this is not what you want to hear, but to a large extent, the opioid prescribing crisis is a function of problems in our health care system. We have a dramatically fragmented, uncoordinated, somewhat haphazard system. It is staffed by persons doing incredible work, but the system itself is very, very difficult. I am sure you have been told a hundred times that the opioid crisis is a wicked problem. One of the definitions of a wicked problem is it is part of another problem, and so anything we can do to fix our health care system would be really useful.

I do think that something like the Ryan White program is the gold standard, but I also think we have wonderful health department and Medicaid directors, including those in Indiana, who have got great imaginations and if given the right kind of funding and discretion can find the levers to pull here.

We have got managed care entities who are working with Medicare and Medicaid that know how to create wraparound services and provide metrics and be accountable for them, and we have states that are using Section 1115 behavioral health waivers to design some really interesting, innovative, and quite different types of care coordination case management models. And we need to maybe ask someone if we could take the budget-neutral piece out of those Section 1115 waivers and see what we can do to really let those people fly and innovate.

Senator CORTEZ MASTO. Thank you.

And I know my time is up. May I follow up, Madam Chair?

The CHAIRMAN. Yes.

Senator CORTEZ MASTO. So let us talk about this wraparound services because I absolutely agree. How do we ensure we are funding those services and people are getting to the type of treatment they need? Not everybody needs the same type of treatment, and how do we as individuals who are ensuring—we are putting funding out there to focus on treatment. How do we know the right kind of treatment is being created in our communities?

And let me open that up. I do not know, Mr. Stauffer or Dr. Pattavina, if you have any ideas.

Mr. STAUFFER. Yes. First, I want to comment that this is our leading public health crisis in the United States, not just the opioid epidemic. It sits inside of a larger issue.

The White House has noted that it is costing us 2.8 percent of our GDP, in addition to driving down life expectancy in the United States.

I think we have to stop focusing on episodic care. We need to focus on long-term needs and ensuring that our community gets help.

When somebody gets a cancer diagnosis in the United States, there is a focus on getting that person to be in remission for 5 years. Everybody knows that that is what is needed. Reframing our system to ensure that that is the case, so if one particular treatment does not work, that you try another one.

The needs of older adults, as was mentioned by the testimony of my colleague here, they are really complex. So we need to make sure that there is enough funding there for service providers to properly serve the person, or else we will end up with haphazard care.

And I applaud the Office of Inspector General's efforts to hold people accountable and programs accountable who are doing bad things. That is really important to the recovery community, and those steps are what we need to do to move toward making sure that there is effective care in the United States.

Senator CORTEZ MASTO. Thank you.

Dr. PATTAVINA. Thank you, Senator.

I have a few thoughts. I guess the easy answer would be there just are not enough of so many types of services, maybe particu-

larly residential or recovery services, but I know you have all been part of appropriating a lot of money toward these things. And it can be frustrating to you that it has not been spent yet, so I know that is an issue.

One of the thoughts I have had is Suboxone, and I refer to it by its brand name because it is a combination product and it otherwise would have a very long name.

It really belongs in sort of the medical home of primary care, as you were alluding to earlier or outright said. It is a person's medical need, and in many cases, these people are already patients of a primary care practice, and they either have not divulged it or the practitioner is unaware of it, has not figured it out, or in many cases practices actually discourage people from becoming Suboxone providers and getting the X waiver. So that is a problem. I could go into some reasons I think that is a problem.

But I also appreciate the efforts—and I apologize if others of you are also sponsors of the effort to codify the 275 in the law, but that is definitely a step in the right direction.

I would suggest we think about going even further, though, and removing all the special requirements around prescribing Suboxone, since it is about as harmless as naloxone. And we certainly in medicine deal with medications that are much more dangerous than that and particularly in emergency medicine.

You may not have seen it, but there was an article in last month's Atlantic about the French experience, and we are not France, but we can always learn from other people. And in 1995, they removed all of the requirements, the special requirements for prescribing Suboxone. The number of people on it went up 10 times, and overdose deaths went down 79 percent in a period of time. Of course, that was an Atlantic article. You people have access to good facts, but I strongly suggest we look into that.

Senator CORTEZ MASTO. Thank you.

Thank you, Madam Chair.

The CHAIRMAN. Thank you, Senator.

I am going to follow up on the point that you just raised about Suboxone because I am a cosponsor of the legislation that codified the expansion, but I am fascinated, Dr. Pattavina, about what you just said because I have noticed in Maine that there is still a hesitation by a lot of primary care physicians to take the training that would allow them to administer Suboxone.

And particularly in the more rural areas of the state, where we do not have treatment centers, we really need for primary care physicians—and I would argue physician assistants and advanced practice nurses—to be willing to do that.

So what do you see, looking at a rural state like ours, as the primary barrier because I expected a big increase once we got the regulatory relief, and we have seen an increase, but it has not been near what I would have hoped.

Dr. PATTAVINA. Yes. It is a little perplexing. In fact, in Machias and Calais, the emergency departments there are attempting to start programs where they would start people on the medication because the emergency clinicians have the waiver or are getting it, yet there is no one in the community to hand them off to. And that is a real barrier.

There is the stigma, unfortunately, and I suspect there is perhaps even a fear that maybe a practice that was doing this might attract more of these people who know. Although, most of them are like you and me. There is fear that they might be disruptive or things like that, and I know practices do in fact screen patients prior to accepting them as part of the practice by looking at the PMP and their medication lists and things.

But I think it really needs to be a change in consciousness that filters to the people out there in practice that this is a person's medical need, and you may already have these people in your practice. And it would not be a bad thing to have more of them.

But the training itself is a little bit of a barrier for a physician. It is eight hours, which is eight fewer hours with your family or at work, but that is not huge. But a lot of it is just not knowing. So somehow we need to do a better job of getting that out there.

The CHAIRMAN. That is very helpful because one of my theories was that perhaps if you are a primary care physician in a smaller community that you are worried that your whole practice is going to end up being treating those with substance abuse problems and opioids in particular, and you want more of a variety in your practice. And there is such a need, unfortunately, in our state, and it seems like the rural areas are even more affected.

And I see Professor Terry nodding that that is the case. I know that has been the case in Indiana, and so that we really need those primary care physicians.

Did you want to add something to that, Mr. Terry?

Mr. TERRY. No. I was nodding that was the correct thing. The treatment centers in rural areas are very low percentage.

We have a shortage of psychiatrists in the country. The number of psychiatrists are not growing as fast as other medical specialties or primary care physicians. Psychiatrists tend to be older. They tend to live in urban areas.

And I think we have to recognize that while we have some drugs that are miraculous, like naloxone, which brings people almost back from death, treatment is not like that, and we salute those who take the long path and are successful. But for most people, even really good medication-assisted treatment is not always going to be successful. It is time-intensive for providers. People relapse. They try and go back into work. They get drug-tested. They then have work problems.

So taking a step back and really trying to assemble multiple strategies for dealing with these issues is so important.

The CHAIRMAN. Mr. Stauffer?

Mr. STAUFFER. And I would just want to add that we do not have a panacea, and so buprenorphine can be life-saving. It is best from the literature, I have seen. Combined with therapy and peer-support services. So we want to have great caution to make sure that we are doing more than just medication, that we are combining it and coordinating. So what can be done at the federal level is really thinking about how do we ensure that those other services occur in combination with the medication for its most effective result.

The CHAIRMAN. Dr. Pattavina?

Dr. PATTAVINA. Yes. I would like to agree with that. It is medication-assisted therapy, and I think that could be a roadblock as well,

having a primary care practice need to coordinate the medication with counseling. And to be fair, it is an added expense as well. They have to do pill counts and periodic testing to make sure the patient is taking the medication. So I know that is an issue as well.

The CHAIRMAN. Thank you.

Mr. Cantrell.

Mr. CANTRELL. Thank you.

I just wanted to highlight some work that we have under way that may help shed light on this issue of access to buprenorphine.

We are looking at a number of certified prescribers, certified by SAMHSA to prescribe buprenorphine across the country, looking at geographic distribution of those that are certified, and also mapping that against those counties where there, based on data from the CDC and SAMHSA, appear to be the greatest need because of overdose rates or prescribing practices. And that work is under way. We want to follow up that work with surveys to certified prescribers to delve into some of these issues, so a preview of some work that is to come.

The CHAIRMAN. We will be having you back. I have no doubt.

Mr. CANTRELL. Great.

The CHAIRMAN. Dr. Pattavina.

Dr. PATTAVINA. Just one more piece of information you might be interested in, if you do not have it, is in Maine, there are 600 people certified to prescribe Suboxone, and they can choose whether or not to be listed on the DEA Web site, I think it is. Only 260 of them are listed there, and only five are prescribing at the limit. And it gets even worse: two of them are at the 30 limit, and the other three are at the 100 limit.

The CHAIRMAN. That is fascinating and tells you a lot about the concerns and the stigma also, I think.

Senator Casey.

Senator CASEY. Mr. Cantrell, I wanted to ask you a question about some of our responses in the Medicare context. The office, your office, shows that one in three people with Medicare Part D are prescribed opioids. The fact that that is the case makes clear that seniors are among those most at risk here.

This fact has not been the real focus, frankly, of much policy debate or all that much press attention or even academic study, which Mr. Stauffer pointed out in his testimony. Older adults are among the most unseen in this whole crisis.

I guess two parts. What additional analyses is OIG planning to do to shed light on these issues? Or I guess another way of asking that, what additional investigations, if any?

Mr. CANTRELL. The first thing we are doing is we are releasing an update, as I mentioned earlier, regarding the data we put forth regarding 2016 prescribing. We will be looking to see where those trends are headed, how many patients are receiving those extremely high dosages based on 2017 claims data.

We are also interested in looking at Medicaid data. We do not have great access to national Medicaid data, so we cannot replicate the analysis that we have done in Medicare across all 50 states, but we will be looking one state at a time to conduct the same analysis to see what is happening in the Medicaid programs. So I think those are important areas that we will continue to monitor.



We are also working very closely with CMS as well as our partners. When we identify these beneficiaries, we share them back to CMS so that they can monitor these patients as well and utilize whatever tools they have available to them to help care for these individuals.

We also shared the outlier prescribers, and I am a member of the Health Care Fraud Prevention Partnership, which is public and private payers. And we have data use agreements and data sharing agreements through that partnership, so we can share data like that, and we have, through the partnership, so that all these private plans can look to see if they are impacted by these outlier prescribers as well.

So we know it is not something we can do alone. So we are ensuring that we make the data that we have available to us as accessible as we can while, of course, honoring security and privacy requirements, but also teaching others how to do the same analysis so that everyone can perform at least the same types of analysis that we are.

Senator CASEY. Thanks very much.

The CHAIRMAN. Thank you.

Senator Cortez Masto, I almost called you "Doctor." I do not know why.

Senator CORTEZ MASTO. That is OK. Thank you.

Let me follow up, Mr. Cantrell, because this was something I was thinking about, and you actually touched on it. I think there is a connection here.

So in many of the Attorneys General offices across the country, including in Nevada, there is a Medicaid fraud unit, and the focus—most people do not realize. That is why I know senior care is a focus of this Medicaid fraud, the level of care that is provided to our seniors and the fraud that goes along with it.

I think there are additional resources to address the law enforcement piece through our state law enforcement and not just rely on federal law enforcement, where there is this fraud associated with opioid abuse, and the connection to CMS because, as we know, CMS is the overseer for those Medicaid fraud units. And I think there is an opportunity. If there is a way that I can help work or we can help work and kind of tear down those barriers or connect those dots, I think that would be helpful as well.

Mr. CANTRELL. We have an outstanding relationship with the Medicaid fraud control units. They are our partners. We work together in the field, and we learn from one another. So there is no concern regarding the relationship with our Medicaid fraud control unit partners, and we do work closely with them in these districts where opioids are a problem, to look across both the Medicaid and the Medicare data.

In fact, OIG oversees the grants for funding the Medicaid fraud control units, and so we have a very close and tight relationship with those units. And we work very well together.

We could use better national Medicaid claims data. That is something that CMS is working toward. We are not there yet, so we still cannot leverage that data the same way we can the Medicare data.

Senator CORTEZ MASTO. That is good to hear, and however we can be helpful, please let me know or let us know.

Thank you.

Mr. CANTRELL. Thank you.

The CHAIRMAN. Thank you very much.

Well, I want to thank Senators for getting here and being very efficient with their questions, since the votes are going to start in 3 minutes.

I want to thank all of our witnesses.

[Voting Notice Clock Buzzes.]

There it is.

Mr. Stauffer, you in your statement wrote something that really summarizes why we are having this hearing today, and you said that substance abuse conditions in older adults receive scant attention in the literature and that there is almost no training for medical professionals to identify and refer persons to care for a substance use condition to get the help that they need. And I would add to that that there is a lack of awareness that substance abuse and opioid addiction is not just a problem affecting young people, and the spike in emergency room admissions for those age 55, I think it was, an older by a third demonstrates that.

So I hope that our hearing today will raise greater awareness of the challenges that are facing older Americans, particularly those who do have chronic pain and may have been on a large dosage of opioids for many, many years, and theirs is a difficult issue for health care providers and for the patient and the patient's family.

We also need to—and I believe have done today—highlight opportunities to improve care for all those who are struggling with addiction, and that does mean better care coordination. I thought Dr. Pattavina's point that it is not just a matter of giving the medication-assisted therapy. It is called "medication-assisted therapy" for a reason, and if it is not surrounded with those wraparound services, it is less likely to be effective.

And, of course, GAO's contributions and the OIG's contributions are always extremely valuable. The Inspector General's report has some really startling statistics.

And, as usual, Senator Cortez Masto anticipated my question because I was wondering what happens to those providers who we know are outliers. Are they given guidance and, thus, monitored by their peers? Are they turned over to the Medicare task force? Are they turned over to state medical boards? What happens? And that is an area that we will be looking further into as well.

But I want to thank all of you for sharing your insights with us as we grapple with this problem.

As Dr. Pattavina mentioned, I was so discouraged when the numbers of those who overdosed in the State of Maine last year actually increased by 11 percent, despite far greater awareness, despite new programs, new approaches, and yet we did not see any improvement. We went backward.

So, clearly, more needs to be done, and I think more help is on the way. But I really want to make sure that this \$6 billion, which is a lot of money, gets down to the local level, and that is something I think we are going to have to work on.

Senator Casey, I would invite you for any closing thoughts.

Senator CASEY. Thank you, Madam Chairman, and thanks for holding this hearing. It is critically important.

I also want to thank all our witnesses for your presence here today, your testimony.

Bill, thank you for making the trip from Pennsylvania and for your service to the people of Pennsylvania and sharing it from your own personal perspective as well as all the experience you have in helping us better understand this challenge.

As we heard today, the opioid crisis is affecting big cities and suburban communities, small towns, and rural areas. It is affecting every generation. There is no bounds of age. We all have a sacred responsibility to care for pregnant mothers and their newborn infants struggling to overcome opioid misuse. We have a responsibility to the unsung heroes of this crisis—grandparents who are now raising their grandchildren.

Today, we learned that one too many senior is struggling to access proven treatments for opioid misuse. The Federal Government must use every tool at its disposal to blunt the harms of this crisis.

So we look forward to continuing to work with folks in this room and folks all across the country and here in the Senate on a bipartisan basis.

Last, I will just make one point at the end. I was going to get to one of these in my questions on Medicaid. Medicaid covers opioid treatment for 4 in 10 Americans. In fact, in 2014, Medicaid was the second largest payer, second only to state and local governments for opioid treatment. So when we are debating how to deal with the opioid crisis, we have got to protect Medicaid.

Madam Chair, thank you very much.

The CHAIRMAN. Thank you.

Senator Cortez Masto, do you have any final thoughts?

Senator CORTEZ MASTO. No, Madam Chair. Thank you.

The CHAIRMAN. Thank you.

I want to thank our staff also for their hard work on this hearing, and Committee members will have until Friday, June 8th, to submit any questions for the record. So it is possible some additional questions will be coming your way.

Again, thank you for your participation. This hearing is now adjourned.

[Whereupon, at 3:19 p.m., the Committee was adjourned.]



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## **APPENDIX**

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## **Prepared Witness Statements**

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**Prepared Statement of Gary Cantrell  
Deputy Inspector General for Investigations  
Office of Inspector General, Department of Health and Human Services**

Good afternoon, Chairman Collins, Ranking Member Casey, and distinguished members of the Committee. I am Gary Cantrell, Deputy Inspector General for Investigations with the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG).

I appreciate the opportunity to appear before you to discuss how OIG is combatting the opioid crisis in Federal health care programs.

OIG's mission is to protect the integrity of HHS programs and the health and welfare of the people they serve through prevention, detection, and enforcement. To accomplish our mission, OIG uses data analytics and real-time field intelligence to detect and investigate program fraud and to focus our resources for maximum impact. We are a multidisciplinary organization comprised of investigators, auditors, evaluators, analysts, clinicians, and attorneys. In addition, we depend on strong public and private partnerships to ensure coordinated enforcement success. OIG has for several years, identified curbing the opioid epidemic as one of the Department's Top Management and Performance Challenges. Key components of that challenge include addressing inappropriate prescribing of opioids, inadequate access to treatment, and misuse of grant funds. In addition, combatting fraud issues, such as drug diversion and fraud committed by providers, presents a significant challenge for the Department.<sup>1</sup>

OIG has a longstanding and extensive history of enforcement and oversight work focused on prescription drug fraud, drug diversion, pill mills,<sup>2</sup> medical identity theft, and other schemes that put people at risk of harm. Several years ago, OIG detected—and began taking action to address—a rise in fraud schemes involving opioids, as well as associated potentiator drugs. In addition to increasing our investigative efforts to combat prescription drug abuse, we have responded to the growing severity of the opioid epidemic by focusing on work that identifies opportunities to strengthen program integrity and protect at-risk beneficiaries. OIG uses advanced data analytics tools to put timely, actionable data about prescribing, billing, and utilization trends and patterns in the hands of investigators, auditors, evaluators, and government partners. Our goal is to identify opportunities to improve HHS prescription drug programs to reduce opioid addiction, share data and educate the public, and identify and hold accountable perpetrators of opioid-related fraud.

In my testimony today, I will highlight law enforcement activities led by my Office of Investigations and discuss OIG projects currently underway to combat opioid-related fraud, waste, and abuse. I also will highlight key OIG recommendations that would, if implemented, have a positive impact on the opioid problem.

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<sup>1</sup> Drugs that enhance the high or euphoria when combined with controlled substances.

<sup>2</sup> A pill mill is a doctor's office, clinic, or health care facility that routinely prescribes controlled substances—such as oxycodone—outside the scope of professional practice and without a legitimate medical purpose.



## OIG'S OFFICE OF INVESTIGATIONS TARGETS FRAUD, WASTE, AND ABUSE

OIG's Office of Investigations has investigators covering every State, the District of Columbia, Puerto Rico, and other U.S. territories. We collaborate with other Federal, State, and local law enforcement authorities to maximize our impact. Special Agents in our Office of Investigations have full law enforcement authority and use a broad range of investigative actions, including the execution of search and arrest warrants, to accomplish our mission. OIG and its law enforcement partners combine resources to detect and prevent health care fraud, waste, and abuse. During the last 3 fiscal years (FYs 2015 to 2017), OIG investigations have resulted in more than \$10.8 billion in investigative receivables (dollars ordered or agreed to be paid to Government programs as a result of criminal, civil, or administrative judgments or settlements); 2,650 criminal actions; 2,211 civil actions; and 10,991 program exclusions.<sup>3</sup>

Much of OIG's investigative work involves the Medicare and Medicaid programs and is funded by the Health Care Fraud and Abuse Control Program (HCFAC). The HCFAC provides funding resources to the Department of Justice (DOJ), HHS, and OIG, which are often used collaboratively to fight health care fraud, waste, and abuse. Since its inception in 1997, the HCFAC has returned more than \$31 billion to the Medicare trust fund. OIG is a lead participant in the Medicare Fraud Strike Force, which combines the resources of Federal, State, and local law enforcement entities to fight health care fraud across the country. Finally, OIG collaborates with State Medicaid Fraud Control Units (MFCUs) to detect and investigate fraud, waste, and abuse in State Medicaid programs.

## THE OPIOID CRISIS

Opioid use is a rapidly growing national health care problem, and our Nation is in the midst of an unprecedented opioid epidemic.<sup>4</sup> More than 60,000 Americans died from drug overdoses in 2016, of which 66 percent reportedly involved opioids.<sup>5</sup> Deaths from prescription pain medication remain far too high, and in 2016, there was a sharp increase in deaths involving synthetic opioids such as fentanyl and an increase in heroin-involved deaths.<sup>6</sup> According to the Centers for Disease Control and Prevention (CDC), approximately three out of four new heroin users report having abused prescription opioids prior to using heroin. Prescription drug diversion—the redirection of prescription drugs for an illegal purpose—is a serious component of this epidemic.

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<sup>3</sup> OIG has the authority to exclude individuals and entities from federally funded health care programs. The effect of an exclusion is that no payment will be made by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. No program payment will be made for anything that an excluded person furnishes, orders, or prescribes.

<sup>4</sup> Centers for Disease Control and Prevention, *Prescription Painkiller Overdoses at Epidemic Levels* [press release], Nov. 1, 2011.

<sup>5</sup> Centers for Disease Control and Prevention, Data Brief 294, *Drug Overdose Deaths in the United States, 1999-2016*, December 2017, and supplement tables.

<sup>6</sup>*Ibid.*

## OIG'S OPIOID FRAUD ENFORCEMENT EFFORTS

Opioid fraud encompasses a broad range of criminal activity from prescription drug diversion to addiction treatment schemes. Many of these schemes can be elaborate, involving complicit patients or beneficiaries who are not ill, kickbacks, medical identity theft, money laundering, and other criminal enterprises. Some schemes also involve multiple co-conspirators and health care professionals such as physicians, nonphysician providers, and pharmacists. These investigations can be complex and often involve the use of informants, undercover operations, and surveillance.

### *2017 National Health Care Fraud Takedown*

OIG and our Medicare Strike Force partners led the 2017 National Health Care Fraud Takedown. The Takedown was the largest ever health care fraud enforcement action, resulting in 412 charged defendants across 41 Federal districts, including 115 doctors, nurses, and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately \$1.3 billion in false billings. Over 120 defendants, including doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics.<sup>7</sup> OIG also announced 295 opioid-related exclusions. The enforcement operation brought together more than 1,000 Federal and State law enforcement personnel, including 350 OIG Special Agents and 30 MFCUs.

### *Case Examples*

OIG agents have investigated the following cases. These examples highlight opioid schemes involving prescription and treatment fraud:

#### *Prescription Fraud*

- In Tennessee, Dr. Abdelrahman Mohamed and his wife Cecilia Manacsa were sentenced to 36 months and 16 months imprisonment, respectively, after pleading guilty to charges of conspiracy to commit health care fraud and health care fraud. In addition to his prison sentence, Mohamed also paid \$730,000 in restitution. Mohamed was the owner and only physician on staff at Hamblen Neuroscience Center, a neurology and pain management center. Between January 2012 and September 2016, Mohamed developed a scheme with Manacsa to schedule, on average, between 40 and 60 pain management patients per 6-hour day worked by Mohamed. To deal with the high volume, staff were often instructed to line up the patients in the hallway outside of Mohamed's office, escort patients into the office for a 1- to 2-minute open-door meeting, then hand Mohamed a partially completed prescription for an opiate pain management medication, which he signed and gave to the patient. After the visits, Mohamed and Manacsa instructed staff to submit fraudulent bills to TennCare and Medicare for services not actually provided to patients.
- In Michigan, Dr. Sardar Ashrafkhan was sentenced to 23 years in prison for participating in a conspiracy to illegally distribute prescription pills, conspiracy to commit health care

<sup>7</sup> Department of Justice, *National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for \$1.3 Billion in Fraud Losses*, July 2017.

fraud, and money laundering. Dr. Ashrafkhan operated a fraudulent medical practice known as Compassionate Doctors that purported to be a visiting physician's practice, but was actually a scheme that involved patient marketers bringing paid "patients" to residences to obtain fraudulent prescriptions for controlled substances. Medicare was billed for medical examinations and tests that were not conducted properly or not conducted at all. Marketers filled the prescriptions for controlled substances at cooperating pharmacies and sold the drugs on the street market. Dr. Ashrafkhan was responsible for participating in illegally distributing more than 200,000 dosage units of oxycodone (including Oxycontin) and Opana, powerful Schedule II opiates. He was also responsible for participating in the illegal distribution of 1 million dosage units of another opiate, hydrocodone (Vicodin, Lortab) and over 3 million dosage units of controlled substances of all kinds.

#### *Treatment Related Fraud*

- In a Pennsylvania case, Dr. Alan Summers was sentenced to 48 months in prison and ordered to pay over \$4.6 million in restitution after pleading guilty to charges of conspiracy to distribute controlled substances, distribution of controlled substances, health care fraud, and money laundering. Dr. Summers ran a clinic that sometimes operated under the business name NASAPT (National Association for Substance Abuse-Prevention & Treatment). Co-defendants Dr. Azad Khan and Dr. Keyhosrow Parsia were employed by Dr. Summers. The defendants executed a scheme in which they sold prescriptions for large doses of Suboxone and Klonopin in exchange for cash payments. Experts testified at trial that Suboxone and Klonopin should never be prescribed together except in rare cases when absolutely necessary. At the clinic, virtually all customers received prescriptions for both Suboxone and Klonopin regardless of their medical need. During the duration of the conspiracy, Dr. Khan and other doctors at the clinic illegally sold more than \$5 million worth of these controlled substances. Almost all of the prescriptions for Suboxone and Klonopin were preprinted before the customer met with a doctor. Khan and the other doctors working at the clinic failed to conduct medical examinations or mental health examinations as required by law to legally prescribe these controlled substances. Several customers who frequented the clinic testified that they were, in fact, drug dealers or drug addicts who sold the prescribed medications. Three other doctors involved in the scheme have pleaded guilty and have either already been sentenced or await sentencing.
- In Massachusetts, Dr. Punyamurtula Kishore and his company, Preventive Medicine Associates, Inc., pled guilty to charges of Medicaid kickbacks, Medicaid false claims, and larceny. Dr. Kishore owned and managed a network of 29 medical branches throughout Massachusetts under Preventive Medicine Associates and engaged in a complex scheme to pay bribes and kickbacks to induce the owners of sober homes to have their residents use his labs for drug screening of their urine samples. Drug screens are generally billed to the Massachusetts Medicaid program, MassHealth, for approximately \$100 to \$200. Dr. Kishore manipulated his business relationships with owners of sober homes to illegally obtain tens of thousands of drug screens paid for by MassHealth for sober house residents who were never treated by Preventive Medicine

Associates providers. Dr. Kishore was sentenced to serve 11 months of imprisonment followed by 10 years of probation and ordered to pay \$9.3 million in restitution.

## OIG'S EFFORTS TO COMBAT THE OPIOID EPIDEMIC GO BEYOND ENFORCEMENT

### *Data analysis to identify questionable prescribing, dispensing, and utilization of opioids*

OIG uses data analytics to detect and investigate health care fraud, waste, and abuse. We analyze billions of data points and claims information to identify trends that may indicate fraud, geographical hot spots, emerging schemes, and individual providers of concern. At the macro level, OIG analyzes data patterns to assess fraud risks across Medicare services, provider types, and geographic locations to prioritize and deploy our resources. At the micro level, OIG uses data analytics, including near-real-time data, to identify potential fraud suspects for a more in-depth analysis and efficiently target investigations.

In July 2017, OIG released a data brief entitled *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*<sup>8</sup> in conjunction with the 2017 National Health Care Fraud Takedown. We found the following:

- One in three Medicare Part D beneficiaries received opioids in 2016. In total, 14.4 million beneficiaries received an opioid prescription that year.
- Approximately 500,000 beneficiaries received high amounts of opioids. Beneficiaries with a cancer diagnosis and those enrolled in hospice were excluded from the analysis. To identify these beneficiaries, OIG looked at the morphine equivalent dose (MED) received by each beneficiary, which equates all of the various opioids and strengths into one standard value. Beneficiaries who received high amounts of opioids had an average daily MED greater than 120 mg for at least 3 months in 2016. A daily MED of 120 mg is equivalent to taking 12 tablets a day of Vicodin 10 mg or 16 tablets a day of Percocet 5 mg. These dosages far exceed the amounts that the manufacturers recommend. Although beneficiaries may receive opioids for legitimate purposes, these high amounts raise concern due to the health risks associated with opioids.
- Within that group, OIG identified nearly 90,000 beneficiaries at serious risk of opioid misuse or overdose. OIG identified two groups of beneficiaries at serious risk of opioid misuse or overdose: (1) beneficiaries who received extreme amounts of opioids and (2) beneficiaries who appeared to be “doctor shopping.”<sup>9</sup>
  - OIG identified 69,563 beneficiaries who received extreme amounts of opioids. They each had an average daily MED of more than 240 mg for the entire year.

<sup>8</sup> OIG, *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*, OEI-02-17-00250, July 2017.

<sup>9</sup> Other beneficiaries may also be at serious risk of opioid misuse or overdose, but they were not the focus of this data brief.

- OIG also identified 22,308 beneficiaries who appeared to be doctor shopping. They each received high amounts of opioids and had four or more prescribers and four or more pharmacies for opioids. While some of these beneficiaries may not have been doctor shopping, receiving opioids from multiple prescribers and multiple pharmacies may still pose dangers from lack of coordinated care. Typically, beneficiaries who receive opioids have just one prescriber and one pharmacy.
- OIG identified about 400 prescribers with questionable opioid prescribing for beneficiaries at serious risk. In the data brief, a total of 401 prescribers stood out as having questionable prescribing because they ordered opioids for higher numbers of beneficiaries at serious risk (i.e., those who received extreme amounts of opioids or appeared to be doctor shopping). In total, prescribers with questionable billing wrote 265,260 opioid prescriptions for beneficiaries at serious risk, costing Part D a total of \$66.5 million.

Although some patients may legitimately need high amounts of opioids, questionable prescribing can indicate that prescribers are not checking State databases that monitor prescription drugs, or that they are ordering medically unnecessary drugs that may be diverted for resale or recreational use. Another possibility is that the prescriber's identification was sold or stolen and is being used for illegal purposes. Questionable levels of prescribing also raise significant concern that prescribers may be operating pill mills.

Ensuring the appropriate use and prescribing of opioids is essential to protecting the health and safety of beneficiaries and the integrity of Part D. Prescribers play a key role in combatting opioid misuse. They must be given the information and tools needed to appropriately prescribe opioids when medically necessary. States' prescription-drug-monitoring programs can provide invaluable information to prescribers about a patient's opioid prescription history. Prescribers must be vigilant about checking the State monitoring databases to ensure that their patients are receiving appropriate doses of opioids and to better coordinate patient care. At the same time, the Department must address prescribers with questionable prescribing patterns for opioids to ensure that Medicare Part D is not paying for unnecessary drugs that are being diverted for resale or recreational use.

*Identify opportunities to improve HHS programs*

Across multiple operating divisions and programs, HHS has many opportunities to help curb this epidemic. Medicare provides prescription drug coverage for 41 million Part D beneficiaries and Medicaid for almost 69 million beneficiaries. The U.S. Food and Drug Administration (FDA) oversees the approval and safe use of prescription drugs. Agencies such as the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the CDC award grants to support health care providers, researchers, and States in their efforts to combat the epidemic.

OIG audits and evaluations address opioid issues by identifying opportunities to strengthen program integrity and protect at-risk beneficiaries across HHS programs. OIG currently has numerous opioid-related audits or evaluations underway. They address the following issues:

- questionable prescribing patterns in Medicaid;
- Medicaid program integrity controls;
- Medicare program integrity controls in the prescription drug benefit;
- CDC's oversight of grants to support programs to monitor prescription drugs;
- FDA's oversight of opioid prescribing through its risk management programs;
- SAMHSA's oversight of opioid treatment program grants;
- beneficiary access to buprenorphine medication-assisted treatment; and
- opioid prescribing practices in the Indian Health Service.

In addition, as part of its strategy to fight the opioid crisis and protect beneficiaries, OIG will soon release a new data brief on opioid use in Medicare Part D.<sup>10</sup> It is a followup to a previous data brief, *Opioids in Medicare Part D: Concerns About Extreme Use and Questionable Prescribing* (OEI-02-17-00250), which was based on 2016 data. The new data brief is based on 2017 data and, like the previous one, will (1) determine the extent to which Medicare Part D beneficiaries received high amounts of opioids, (2) identify beneficiaries who are at serious risk of opioid misuse or overdose, and (3) identify prescribers with questionable opioid prescribing patterns for these beneficiaries.

In conjunction with the new data brief, OIG will also release an analysis toolkit.<sup>11</sup> It is based on the methodology that OIG has developed in our extensive work on opioids. The toolkit provides detailed steps for using prescription drug data to analyze patients' opioid levels and identify those at risk of opioid misuse or overdose, such as those who receive extreme amounts of opioids or appear to be doctor shopping. The purpose of the toolkit is to assist our public and private sector partners with analyzing their own prescription drug claims data to help combat the opioid crisis.

OIG is also focused on effective public health approaches to prevention and treatment. Currently, we are conducting an evaluation to examine access to Medication-Assisted Treatment (MAT) for opioid use disorder. MAT, including buprenorphine, is a key component of effective treatment for opioid use disorder. Congress has taken sustained action to support MAT services through broadened prescribing authorities and increased Federal funding. However, a treatment gap continues to exist where an estimated 10 percent of the people in the United States who need treatment receive it.

To address this treatment gap, we are examining access to MAT through the SAMHSA buprenorphine waiver program, which permits providers to prescribe buprenorphine to patients in office settings rather than traditional opioid treatment facilities. We are determining the number, location, and patient capacity of providers who have obtained buprenorphine waivers from SAMHSA. We will also determine the extent to which waived providers are located in

<sup>10</sup> OIG, *Opioid Use in Medicare Part D*, OEI-02-18-00220, forthcoming.

<sup>11</sup> OIG, *Toolkit to Identify Patients at Risk of Opioid Misuse*, OEI-07-00560, forthcoming.

areas with high indicators of opioid misuse and abuse (i.e., areas that likely have large numbers of residents in need of treatment services), including whether any of these areas are without waived providers. We anticipate that this report, when finalized, will highlight counties in need of MAT services that do not now have adequate access.

#### **OIG MAXIMIZES IMPACT THROUGH STRONG COLLABORATION WITH PUBLIC AND PRIVATE PARTNERS**

In addition to Strike Force operations and other government collaborations, OIG engages with private sector stakeholders to enhance the relevance and impact of our work to combat health care fraud, as demonstrated by our leadership in the [Healthcare Fraud Prevention Partnership](#) (HFPP) and collaboration with the [National Health Care Anti-Fraud Association](#) (NHCAA). OIG strives to cultivate a culture of compliance in the health care industry through various educational efforts, such as Pharmacy Diversion Awareness Conferences, public outreach, and consumer education.

##### *Medicare Fraud Strike Force*

The Strike Force effort began in Miami in March 2007 and has expanded operations to eight additional cities. Strike Force teams effectively harness the efforts of OIG and DOJ, including Main Justice, U.S. Attorneys' Offices, and the Federal Bureau of Investigation (FBI), as well as State and local law enforcement, to fight health care fraud in geographic hot spots.

The Strike Force teams use near-real-time data to pinpoint potential fraud hot spots and identify aberrant billing. This coordinated and data-driven approach to identify, investigate, and prosecute fraud has produced significant results, highlighted by the July 2017 National Health Care Fraud Takedown. Since its inception in March 2007, the Strike Force has charged more than 3,000 defendants who collectively billed the Medicare program more than \$10.8 billion.

##### *Collaboration with the Department*

OIG collaborates with a number of HHS agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Agency for Community Living (ACL), on fraud and opioid-related initiatives. OIG collaborates with CMS and ACL to educate providers, the industry, and beneficiaries on the role each one plays in the prevention of prescription drug and opioid-related fraud and abuse. We share our analytic methods and data analysis with CMS and work together to identify mitigation strategies and develop follow-up approaches to deal with the prescribers and at-risk beneficiaries identified. OIG engages ACL's Senior Medicare Patrol and State Health Insurance Assistance Program through presentations on the prevention of fraud, waste, and abuse.

##### *Opioid Fraud and Abuse Detection Unit*

OIG provided critical support in the establishment of the new Opioid Fraud and Abuse Detection Unit established by the Attorney General in collaboration with OIG, FBI, and Drug Enforcement Administration (DEA). The unit focuses specifically on opioid-related health care fraud using

data to identify and prosecute individuals who are contributing to the opioid epidemic. This collaboration led to the selection of 12 judicial districts around the country where OIG has assigned Special Agents to support 12 prosecutors identified by DOJ to focus solely on investigating and prosecuting opioid-related health care fraud cases. Each of the 12 districts is supported by OIG, FBI, and DEA.

*The Healthcare Fraud Prevention Partnership and the National Healthcare Anti-Fraud Association*

The HFPP and NHCAA are public-private partnerships that address health care fraud by sharing data and information for the purposes of detecting and combatting fraud and abuse in health care programs. OIG is an active partner in these organizations and frequently shares information about prescription-drug fraud schemes, trends, and other matters related to health care fraud.

*Pharmacy Diversion Awareness Conferences*

OIG has collaborated with the DEA to provide anti-fraud education at numerous Pharmacy Diversion Awareness Conferences held across the United States. The conferences were designed to assist pharmacy personnel with identifying and preventing diversion activity. Since 2013, OIG has presented at conferences in 50 States and Puerto Rico.

**TOP OIG RECOMMENDATIONS FOR CMS RELATED TO THE OPIOID CRISIS**

OIG has made numerous recommendations to improve HHS programs to better protect beneficiaries at risk of opioid misuse or overdose. Specifically, ensuring the appropriate use and prescribing of opioids is essential to protecting the health and safety of beneficiaries and the integrity of Medicare Part D.

As a result of OIG recommendations, Part D has strengthened its monitoring of beneficiaries at risk of opioid misuse. CMS has expanded drug utilization review programs to include non-opioid “potentiator” drugs. These euphoria-enhancing potentiator drugs are often abused in conjunction with opioids and increase the risk of negative outcomes including overdose. CMS now identifies beneficiaries with concurrent opioid and benzodiazepine prescription drug use and will, beginning in 2019, identify beneficiaries who receive high doses of gabapentin in addition to opioids. CMS also expects that when plan sponsors perform case management they would consider the use of these potentiator drugs in their own review processes. Further, CMS has committed to perform analyses to proactively identify other potentiator drugs, meet biannually with OIG to discuss emerging issues, and consider additional enhancements to drug utilization review programs in the future.

Despite the progress made, there are other improvements OIG recommends to protect Medicare beneficiaries.

- 1) Restrict certain beneficiaries to a limited number of pharmacies or prescribers.



OIG recommends that CMS encourage implementation of the new Medicare Part D beneficiary lock-in authority under the Comprehensive Addiction and Recovery Act of 2016 (CARA). Lock-in would restrict certain beneficiaries to a limited number of pharmacies or prescribers when warranted and reduce inappropriate use of opioids among Medicare beneficiaries and Part D fraud. This policy would provide coordination of care for beneficiaries being harmed by overprescribing and address beneficiaries who are doctor shopping or intentionally seeking unnecessary prescriptions.

In 2018, CMS promulgated regulations that govern how Part D sponsors should implement the new lock-in authority under CARA, beginning in 2019. However, the decision of whether to implement this program rests with the Part D sponsors.

- 2) Require plan sponsors to report to CMS all potential fraud and abuse and any corrective actions they take in response.

CMS should collect comprehensive data from Part D plan sponsors to improve its oversight of their program integrity efforts, including the diversion of opioids for illegitimate use. Sponsors serve as the first line of defense against opioid fraud, waste, and abuse in Part D as they are responsible for paying claims and monitoring billing patterns. However, there is currently a lack of transparency on how Part D sponsors identify and investigate these matters.

- 3) Improve Medicaid data.

CMS does not have complete and accurate data needed to effectively oversee the Medicaid program, including opioids. Without accurate claims data, adequate oversight of the Medicaid program is compromised. OIG has a history of work that points to the incompleteness and inaccuracy of CMS's national Medicaid database, the Transformed Medicaid Statistical Information System (T-MSIS). Without a national dataset, CMS, States, and OIG are unable to identify nation-wide trends and vulnerabilities. This hampers program integrity efforts because fraud does not respect State boundaries. OIG recommends that CMS establish a deadline for when national T-MSIS data will be available for multistate program integrity efforts.

## CONCLUSION

OIG has made combatting the opioid crisis a top enforcement and oversight priority. We will continue to leverage our analytic, investigative, and oversight tools, as well as our partnerships in the law enforcement and program integrity communities and with the Department to maximize our efforts. OIG will remain vigilant in following and investigating emerging opioid fraud trends, especially schemes involving patient harm and abuse.

**Prepared Statement of Charles Pattavina, M.D., FACEP, Medical Director and  
Chief of Emergency Medicine, St. Joseph Hospital, Bangor, Maine**

Thank you, Chairman Collins and Ranking Member Casey. My name is Charles F. Pattavina, M.D., FACEP, and I am a practicing emergency medicine physician at St. Joseph Hospital in Bangor, Maine. I am also the immediate past president of the Maine Medical Association and I served on the Board of Directors of the American College of Emergency Physicians from 1997 to 2003. I would like to thank the committee for this opportunity to provide testimony regarding the impact this terrible opioid crisis is having on older Americans.

As you know, the opioid epidemic claims the lives of almost 120 Americans every day and more than one a day in my state of Maine. Each year in the past decade, more Americans have died from drug overdose than from motor vehicle crashes. The CDC recently published data that show a 30% increase in opioid overdose visits to emergency departments between July 2016 and September 2017, including a 32% increase for people ages 55 and over.

I see patients every day who are impacted by this crisis, including many who are older. While the effects of the opioid epidemic on seniors are in large part similar to the effects on the population as a whole, the epidemic does present some unique challenges for older Americans. It seems likely that most seniors who are currently on opioid medications were prescribed them for pain as opposed to younger people who may be more likely to have started with so-called "recreational use." As we know, most people who are now addicted did start on prescription opioids however those opioids were not necessarily prescribed for them but very often obtained through illicit channels.

In addition to being at risk for crime such as having their medications stolen and diverted by caretakers, family members and others, we are seeing many cases in which people who have become dependent on these medications seem to be tapered off them too quickly with little offered in the way of alternative pain management. One of the difficulties we have in treating pain is that the entire class of NSAIDs, nonsteroidal anti-inflammatory drugs which include ibuprofen and naproxen, cannot be used in patients with compromised kidney function or certain other medical problems that are common in older people. Acetaminophen can be used for the most part, and while its power is often underappreciated, it is usually not enough for truly severe pain. Nevertheless, there is a range of pain tolerance among people and a fair amount of variability in how well medications like acetaminophen and the NSAIDs will work.

Prescribing is further complicated by comorbidities, which are more common the longer a person lives, and by interactions with other medications a person may be taking, including anti-anxiety medications (such as the benzodiazepines) and nausea medications. Another problem with prescribing these medications in this age group is the likelihood of magnified effects or undesirable side effects. People in this age group are more susceptible than younger people to confusion, drowsiness, hypoventilation, respiratory arrest, falls (and fractures), constipation and bowel blockage, so the dose must be reduced to a point where it can be hard to break pills into small enough pieces.

One interesting impact of all the publicity about the epidemic and the potential for harm these medications have is that, for example, those in the field of oncology are hearing more often that patients even with terminal cancer are reluctant to be started on opioid pain medication because they fear becoming addicts. This is something we all had heard before but never as much as we are hearing it from patients now.

I was interested and appalled to see some of the data in the HHS OIG data brief of July 2017 concerning extreme use and questionable prescribing practices under Medicare Part D. While I do think prescribing could have been more conservative across the board, it is clear there is a real and very serious problem with a very small number of prescribers and a small number of recipients. I know the OIG stated they are or will be dealing with outlier prescribers and I know one of those ways is through pharmacy lock-in and prescriber lock-in, but we are also doing all we can in Maine to deal with outliers. First, through education - both mandatory and otherwise - we hope to have fewer outliers. The MMA has a contract with Maine's Medicaid program to provide independent, academic clinical information on opioid prescribing, and the contract allows us to target practices identified as higher prescribers through the prescription monitoring program. Specific cases of overprescribing are dealt with by the medical and osteopathic physician licensing boards and the nursing licensing board in Maine.

Regarding the prescription monitoring website, we do have new software in line with what other states have but problems remain. One interesting challenge is that the program is designed only to show pills that were dispensed. Some practitioners feel it would be helpful to know when pharmacists deny attempts to fill opioid prescriptions. While we do have new software, we don't have the most easy to use product from the vendor that now services almost every state. Furthermore, hospitals and other employers have not opted for the ability to link the prescription monitoring site into their electronic records. Where I work, we now use Epic and I have seen that PMP data can flow right into the Epic system. Also, in spite of legislation enacted by Congress last year, I still don't believe I am seeing any record of pills dispensed by the Veterans Administration and that continues to be a major problem.

Patient perception of pain is a real challenge, particularly among those who have been on opioids for long periods of time for chronic pain because they are used to the status quo and fear that nothing will work as well for their pain. Barring exceptions for cancer, end-of-life care, hospice or palliative care, people in Maine are now limited to 100 morphine milligram equivalents per day. Following the enactment of the new prescribing law in Maine, we were quite surprised to see that some patients were on as many as 2,000 equivalents per day and one was actually at 4,000 equivalents per day. Great care and time must be taken to taper anyone's dose, and real alternatives must be offered. This would certainly include nonpharmacologic methods including counseling, as my observations tell me that not everyone suffers from their suffering to the same degree. There is definitely a danger that patients or their family members might seek out street drugs if they feel the pain of their loved one is not being adequately treated.

I am happy to say that there are a lot more resources for recovery than there were just a year ago. I know the limits for prescribing Suboxone have been increased and now PAs and nurse practitioners can prescribe as well. We still need more people to become prescribers of Suboxone however, especially primary care clinicians who in many cases already have these patients in their practice, but the patients may not have divulged their drug problem yet or the practitioners may not realize how easy it would be to help their patients with their drug problems. In addition, there are emergency departments around the country, including at least one in Maine that are starting people on Suboxone and handing them off to clinicians who can continue their medication assisted therapy, including prescribing and counseling.

In my community, thanks to the effort of the Community Health Leadership Board and others, leading practitioners came together and reviewed their own prescribing practices and agreed upon new guidelines. In addition, a psychiatrist brought forth an idea for a social detox center to that same group and it has become a reality, providing a place in Hampden, Maine where we can actually offer detox services to people when previously we had very little or nothing at all.

Nevertheless, serious barriers remain, including lack of insurance coverage. While some of the services are available to people with no insurance, many programs are not available to them and the gold standard of medication assisted therapy, Suboxone, is not adequately covered by some insurance plans and is a barrier for those with no insurance, particularly in states like my own that not only have been blocking Medicaid expansion but have been reluctant to release funds for Suboxone for patients with no insurance. I want to personally thank Senator Collins for her courageous leadership in seeking to expand coverage for Americans and repeatedly blocking attempts to do the opposite.

Also, as you know, there's a great deal of overlap between substance abuse and psychiatric illness and holding psychiatric patients in emergency departments for extended periods for lack of a proper care setting is only getting worse. This is not only bad for their wellness and recovery, it sometimes causes patients who come to us for detox to have to wait long periods of time when they could have been seen fairly quickly and transported to the detox facility. The psychiatric boarding problem has adverse effects on everyone's care.

Another thing that has improved or will improve things is the change in wording of patient satisfaction surveys and federal programs. While there was a strong feeling the old language created a perverse incentive and even pushed practitioners to prescribe more pain medication, the new language, is less likely to have such an effect as long as people answer the question honestly and don't seek to exact retribution for what they perceive as pain management that was not specifically what they had in mind. I want to thank the Senate for your leadership on this issue including those present, and ask that the same language be applied to all federal program surveys. It is the physicians and nurses who are the best at assessing and managing pain so they should be provided with all the necessary tools and their practice should not be excessively encumbered. This is why it is important to take care with any new legislation and not rush too quickly into anything that might have unintended consequences, such as the pharmacy lock-in or similar rules, if they don't contain an exception for emergency care.

**Summary / Call to Action:**

While we now have more tools than ever to address the opioid crisis, much remains to be done, particularly in the areas of removing barriers to inpatient residential treatment and medication assisted therapy. To this end, anything that would increase coverage for these people for these services is essential.

Also, given the overlap between psychiatric illness and substance abuse problems, it is imperative to address the shortage of psychiatric services which causes psychiatric patients to board in the emergency department. This is virtually an everyday problem at my hospital and hospitals across the country.

I would like to see passage of the Opioid Crisis Response Act of 2018 (S. 2680) which essentially includes all the provisions of S. 2610, the Preventing Overdoses While in Emergency Departments Act of 2018, and S. 2516, the Alternatives to Opioids (ALTO) in the Emergency Department Act.

**Prepared Statement of William Stauffer, Executive Director,  
Pennsylvania Recovery Organizations Alliance**

First, I would like to thank Chairman Collins, Ranking Member Casey, and the members of the Committee for hosting this important hearing and for the opportunity to testify on "Preventing and Treating Opioid Misuse Among Older Americans." My name is William Stauffer. I am a person in long term, continuous recovery. For me, that means that I haven't used alcohol or other drugs in over 31 years. I think it is relevant to this committee to note that I received treatment with public dollars. It was the best investment that could possibly have been made in my life and the lives of the people who depend on me.

My recovery has allowed me to give back to my community, earn several college degrees, own a home, be a good husband, volunteer in my community, pay taxes, establish a career, be a college professor and become a leading advocate for the recovery community in the great state of Pennsylvania. It is a life that was beyond my wildest imagination, and the most remarkable thing about it is that my kind of story is quite common in the recovery community. We can and do recover and when we do we do great things, no matter what age we start are recovery journeys. I too will one day turn age 65 and expect to rely on Medicare. I hope that I and all those like me with substance use conditions, will have the full array of recovery services and supports available. Congress should work to ensure that is the case, particularly as 10,000 Baby Boomers turn 65 and become eligible for Medicare each day.

My written and oral testimony are the results of my experience as a person in substance use recovery and well as my professional experience across three decades of service to the substance use recovery community. I am currently the Executive Director of the Pennsylvania Recovery Organizations – Alliance (PRO-A) in which capacity I have served since 2012. Prior to this I have worked since the late 1980s as a professional in the drug and alcohol care system. I have operated residential and outpatient treatment services among other functions. I am also currently an adjunct professor of Social Work at Misericordia University where I developed and teach a course on substance use and older adults.

I would like to start out by acknowledging that opioid overdoses killed 1,354 Americans ages 65 and older in 2016, about 3 percent of the 42,000 opioid overdoses that year. There is evidence that overdoses of older adult Americans are rising faster than other age groups in some regions of the country. There is also some sense that as the baby boomers age, these numbers will continue to climb nationwide. While alarming, this knowledge could allow us to take proactive measures to address the needs of our older adult citizens.

Overall, one in three older Americans with Medicare drug coverage are prescribed opioid painkillers. However, while Medicare pays for opioid painkillers, Medicare does not pay for drug and alcohol treatment in most instances, nor does it pay for all of the medications that are used to help people in the treatment and recovery

process. Methadone, specifically is a medication that is not covered by Medicare to treat opioid use conditions.

The recovery community supports the use of medication as part of the treatment and recovery process and we strongly believe in multiple pathways to recovery. We understand that medications, including Methadone, are important elements in the treatment and recovery process for adults seeking help with an opioid dependency, including older adults. Recovery with medications is a reality for members of our community, as are other pathways.

Older adults are at high risk for medication misuse due to conditions like pain, sleep disorders/insomnia, and anxiety that commonly occur in this population. They are more likely to receive prescriptions for psychoactive medications with misuse potential, such as opioid analgesics for pain and central nervous system depressants like benzodiazepines for sleep disorders and anxiety. One study found that up to 11 percent of women older than age 60 misuse prescription medications. The combination of alcohol and medication misuse has been estimated to affect up to 19 percent of older Americans.

This committee is showing true leadership for focusing on the needs of our older adult citizens. We know full well that substance use conditions affect Americans of all age groups. However, it is also true the needs of older adults who are experiencing a substance use condition are far too often missed or ignored. While substance use conditions have long been an issue for older adults, the topic receives scant attention in the literature and there is almost no training for medical professionals to identify and refer persons to care for a substance use condition to get the help that they need. Even when this is done, the complex needs of older adult patients can mean that there are few if any places to refer them to who specialize in older adult care. Providers who want to meet these needs often cannot, as reimbursement rates are too low to meet these needs properly.

Current projections are that Americans 65 and older will expand from around 15% of our current population to 20% by 2030. All signs point towards these challenges only becoming worse as our demographics continue to shift. The opioid epidemic – which is part of a larger, addiction epidemic, has been devastating to far too many families – and this also holds true for older adults whom we are also losing to senseless overdoses and addiction related medical complications.

In older adult populations, a number of factors have been associated with increased risk of prescription medication misuse, including being female, social isolation a history of substance dependence, chronic pain conditions and mental health disorders, particularly depression. We also know that older adults with substance use conditions fall roughly into two categories. The first category include those who may have had a longer term struggle with substance use conditions, including opioids, they tend to have more complex care needs as they are debilitated, often with fewer social supports and resources. The second group are persons with late onset substance use conditions, including opioid use disorders. Persons in this group typically have

experienced loss or a series of losses that become overwhelming and many often have medical conditions, including chronic pain.

Older adults with substance use conditions face a triumvirate of stigma. Far too often the family, caregivers and physicians fail to see, ignore or underestimate the extent of the problem and the need to seek help. Often, the family and caregiver engage in behavior that reinforces the addiction and ends up causing more harm through neglect. Overall, there may be a prevailing but mistaken sense that the older adult “has earned it” or that it may be one of the few joys left – these views ignore the fundamental pain that underlies addiction at any life stage.

Addiction can be masked by other conditions and stigma can make it difficult for the physician to broach the issue with an older adult patient when it is noticed. Many physicians are not comfortable talking about substance use conditions to their patients in general and age adds an additional element to this dynamic. Far too often, we die when no one steps up to help, and perhaps in no age group is this truer than in older adults.

Multiple drug interactions can make substance use conditions difficult to spot and a challenge to manage once identified. It has been noted that physicians by and large spend less time with older adult patients, adding to the challenge. We also as a society tend to be over reliant on medications – which is how we got into the opioid epidemic in the first place. Physician education is also key in all these areas.

A long-term area of concern is the Institute of Mental Disorders (IMD) Exclusion costs are shifted to our Substance Use block grant and fixing it would help states to use these resources for older adults. We also know that the IMD Exclusion has long been a barrier to funding drug and alcohol treatment. We are deeply grateful to Senator Casey for the many years of support in efforts to get rid of the IMD exclusion. We urge you to remove drug and alcohol from the IMD exclusion, as HR 2938 the Road to Recovery Act would do. It is an important Bill to pass. It would support our efforts by allowing Medicaid financing for care provided in substance use disorder residential treatment facilities larger than 16 beds. This will allow for older adult services to be paid for out of the Substance Abuse Prevention & Treatment Block Grant (SAPTBG) instead of being diverted to cover IMD costs.

We applaud Senator Casey for his bill that would have Medicare pay for methadone. This is an important first step. We would recommend taking additional steps to ensure that older adults get the care they need and ensure that treatment and recovery services are properly funded and that care is integrated with properly educated, supportive and empathetic medical and psychiatric care. We need a full continuum of care available for individuals and families seeking help with a substance use condition, including treatment and peer support services for all age groups.

We applaud efforts being made in Congress to expand medication-assisted treatment to Americans age 65 and older through Medicare. We know that this is fast-growing area of need for older adults in our society. We also know that it is critically



important to provide comprehensive treatment and recovery support services that includes medical, individual and family counseling for all populations.

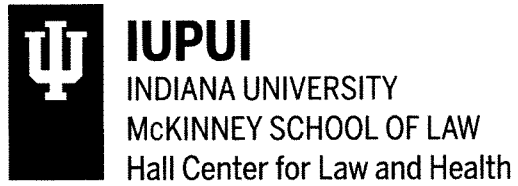
We must expand education for physicians and other medical care practitioners about substance use conditions in general and specifically about the unique challenges that face older adults who experience a substance use condition. We must be cognizant of the challenges of matching older adults with treatment and recovery options that can address their needs, and we must provide funding in sufficient amounts for service providers to support these services. We must ensure that Medicaid is adequately funded to continue to serve as a critical source of coverage for treatment. We in Pennsylvania have seen how Medicaid expansion has been a key source of support for serving our community. Low-income Americans in all states should have that option – it is perhaps the most important rung on the ladder to productivity for our community. It is important to note that among Baby Boomers, Medicaid expansion is particularly important to those ages 50+. We would urge Congress to expand funding for treatment and recovery support services to meet our care needs as treatment and recovery support services save money, families and communities.

In conclusion, supporting access to all medications, treatment and recovery support services that can assist an older adult into the recovery process is a critically important first step in assisting adults over 65 accessing care for an opioid use disorder. Treatment and recovery involve the whole person and we need to consider the unique needs of older adults and as a society more fully value those members of our society in this stage of life.

I would like to end my testimony with a quote, and to note that helping older adults recover from substance use conditions can make all the difference in the world to millions of families across this great nation.

*“Our society must make it right and possible for old people not to fear the young or be deserted by them, for the test of a civilization is the way that it cares for its helpless members.”* - Pearl S. Buck

It was an honor to be given the opportunity to testify on behalf of our community here today, thank you.



**Prepared Statement of Nicolas P. Terry, Professor of Law and Executive Director  
of the William S. and Christine S. Hall Center for Law and Health,  
Indiana University**

**for**

**Hearing on “Preventing and Treating Opioid Misuse Among Older Americans”**

**United States Senate Special Committee on Aging, May 23, 2018**

Thank you Chairman Collins, Ranking Member Casey, and Committee Members for this opportunity to speak with you today. I am a Professor of Law at Indiana University. I serve on the Scientific Leadership team for the University's \$50 million "Responding to the Addictions Crisis Grand Challenge" initiative and, with colleagues from our school of law and school of public health, I am engaged in a research project designed to identify legal and policy barriers to effective opioids interventions.<sup>1</sup>

My testimony will address 3 issues:

- Characteristics of the Addictions Crisis
- Responses to the Crises
- Complicating Factors involving the near-elderly and elderly

#### 1. Characteristics of the Addictions Crisis

I have to admit that, originally, our work did not include an ageing lens, instead focusing on harm reduction and halting the deaths of the young or the middle-aged with Substance Use Disorders (SUD). Broadening the discussion is an important reminder that the opioid crisis is continually morphing. What began as a prescription drug crisis (first opioids, increasingly stimulants<sup>2</sup>) among medical users is now in the shadow of an illegal drug crisis (first, fentanyl, now also cocaine, and methamphetamine<sup>3</sup>) affecting non-medical users. What began as a crisis heavily impacting white, rural middle-aged persons now is affecting urban areas and people of color.<sup>4</sup>

It should be no surprise, therefore, that older adults also are suffering. Older adults make up about 25% of the long-term opioid users<sup>5</sup> and Medicare beneficiaries are the fastest growing

<sup>1</sup> Legal and Policy Best Practices in Response to the Substance Abuse Crisis: A Preliminary Report, March 30, 2018, <https://grandchallenges.iu.edu/doc/iu-grand-challenges-legal-and-policy-best-practices.pdf>.

<sup>2</sup> Charles P. Vega, The Next Wave of Addiction, Medscape, May 16, 2018 (noting "in 2016, first-time recreational use of stimulants outpaced first-time opioid use").

<sup>3</sup> DRUG ENFORCEMENT ADMINISTRATION, 2017 NATIONAL DRUG THREAT ASSESSMENT, DEA-DCT-Dir-040-17 (2017), <https://www.dea.gov/docs/Dir-040-172017-NTA.pdf>. See, also, Peter Phalen et. al., *Fentanyl related overdose in Indianapolis: Estimating trends using multilevel Bayesian models*, (ADDICT. BEHAV. Forthcoming 2018), available at <https://www.sciencedirect.com/science/article/abs/pii/S0306460318301217>; Christine Vestal, *A New Meth Surge Gathers Momentum*, THE PEW CHARITABLE TRUSTS (May 18, 2017), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/05/18/a-new-meth-surge-gathers-momentum>.

<sup>4</sup> Shanoor Seervai, Arnav. Shah, & Eric C. Schneider, *The U.S. Has Two Opioid Epidemics: The Federal Response Should Consider Both*, TO THE POINT (Mar. 22, 2018), <http://www.commonwealthfund.org/publications/blog/2018/mar/federal-response-to-opioids>.

<sup>5</sup> Mojtabai R. National trends in long-term use of prescription opioids. *Pharmacoepidemiol Drug Saf.* 2018;27:526–534. <https://doi.org/10.1002/pds.4278>

population of diagnosed opioid use disorders.<sup>6</sup> The number of seniors with SUD is predicted to double between 2004 to 2020 (1.2% to 2.4%).<sup>7</sup>

## 2. Responses to the Crises

In our research we noted positive steps taken in our state and elsewhere:

1. Making naloxone broadly available and increasing the number of persons who can administer it
2. Improving data management and public health surveillance
3. Expanding Prescription Drug Monitoring Programs and integrating them with electronic health records
4. Establishing supply-side approaches to reducing the number of opioids in circulation by placing limits on the prescription of opioids and instituting take-back and disposal programs, and
5. Increasing policing and other law enforcement efforts to reduce the supply of illegal drugs.

While perfection can be the enemy of the good, sometimes “good” is not good enough. We concluded that we could do much more, specifically:

1. Prioritize harm reduction.
  - Increase the availability of the overdose-reversal drug naloxone
  - Support the work of syringe exchange programs and first responders
  - Create more safe spaces and routes to treatment
  - Reduce stigma and mainstream the addiction state, just as we have tried to do with mental illness
2. Remove legal impediments that hold up effective responses
  - Synchronize Good Samaritan and drug paraphernalia laws
  - Better coordinate federal privacy laws
  - Make it easier for those with substance use disorder to access Medicaid services.
3. Make careful and sustaining investments in healthcare services
  - Invest in more and improved evidence-based treatment services

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<sup>6</sup> CMS, *Opioid Misuse Strategy*, Jan. 5, 2017, <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf>. See also Report (OEI-02-17-00250) Office of the Inspector General, *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*, 07-11-2017:

- One in three Medicare Part D beneficiaries received a prescription opioid in 2016
- About 500,000 beneficiaries received high amounts of opioids
- Almost 90,000 beneficiaries are at serious risk; some received extreme amounts of opioids, while others appeared to be doctor shopping
- About 400 prescribers had questionable opioid prescribing patterns for beneficiaries at serious risk; these patterns are far outside the norm and warrant further scrutiny.

<https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf>

<sup>7</sup> Opioid Use in the Older Adult Population, <https://www.samhsa.gov/capt/tools-capt-learning-resources/opioid-use-older-adult-population>

- Pay for improved care coordination and wrap-around services such as safe housing, and make resources available to offer counseling
- Help those re-entering society avoid a cycle of addiction and incarceration.
- Innovate in providing care for children born with neonatal abstinence disease.

### 3. Complicating Factors involving the near-elderly and elderly

I defer to the expertise of my co-panelists on pharmacology and the nature of addiction among seniors but I would note certain heightened risk factors found in the literature:<sup>8</sup>

- Because of chronic pain the near-elderly and elderly likely will be longer term users of opioids
- Medication sensitivity increases with age
- Polypharmacy,<sup>9</sup> including the use of benzodiazepines, sleep aids, alcohol, and marijuana, that heightens risks associated with SUD
- Drug hoarding and drug sharing
- Co-morbidities that increase the risk of missing a SUD diagnosis<sup>10</sup>
- Long-term use of opioids is more common in near-elderly and elderly population and correlates with chronic health and with populations using public rather than private insurance.<sup>11</sup>
- Opioid use has been associated with fall-related injuries and death among older adults.<sup>12</sup>
- Risks of injury and death are substantially higher amongst older adults with opioid use disorder.<sup>13</sup>
- Rural older adults are dying from the opioid epidemic at a slightly higher rate than older adults generally.<sup>14</sup>

It is clear that not only do many aspects of the crisis apply equally to seniors but also some, specific, complicating considerations come into play.

#### 1. Care Coordination Challenges

<sup>8</sup> See generally Jane Tilly et al, The Opioid Public Health Emergency and Older Adults, Administration for Community Living, Dec. 2017, <http://www.nasud.org/sites/nasud/files/OD%20issue%20brief%20final%20508%20compliant%202-8-17.pdf>.

<sup>9</sup> Charlesworth, C. J., et al (2015). Polypharmacy Among Adults Aged 65 Years and Older in the United States: 1988–2010. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 70(8), 989–995. <http://doi.org/10.1093/gerona/glv013>

<sup>10</sup> Maree, R.D., Marcum, Z.A., Saghaei, E., Weiner, D.K. and Karp, J.F., 2016. A systematic review of opioid and benzodiazepine misuse in older adults. *The American Journal of Geriatric Psychiatry*, 24(11), pp.949-963.

<sup>11</sup> Mojtabai R. National trends in long-term use of prescription opioids. *Pharmacoepidemiol Drug Saf.* 2018;27:526–534. <https://doi.org/10.1002/pds.4278>.

<sup>12</sup> Daoust et al., Recent opioid use and fall-related injury among older patients with trauma. *CMAJ.* 2018 Apr 23;190(16):E500-E506. doi: 10.1503/cmaj.171286.

<sup>13</sup> Larney, S, et al, (2015). Mortality among older adults with opioid use disorders in the Veteran's Health Administration, 2000–2011. *Drug and Alcohol Dependence*, 147, 32–37. <http://doi.org/10.1016/j.drugalcdep.2014.12.019>

<sup>14</sup> William F. Benson and Nancy Aldrich, Rural Older Adults Hit Hard By Opioid Epidemic, *Aging Today*, Sep. 27 2017, <http://www.asaging.org/blog/rural-older-adults-hit-hard-opioid-epidemic>.

Many of the barriers to effective opioid interventions may be laid at the feet of our healthcare system. They include access problems (particularly for the very poor and the poor), high and increasing costs (including insurance costs, prescription drug costs, and cost-shifting), substandard care coordination, a frequently incoherent healthcare delivery model involving multiple types of entities and financing or reimbursement models, inadequate wraparound services, and severe deficiencies in data management and sharing.

The need for improved coordination frequently has been cited by organizations such as the National Academies of Science,<sup>15</sup> the Agency for Healthcare Research and Quality,<sup>16</sup> and the National Quality Forum.<sup>17</sup> Successful care coordination has several key pillars, including “access to a range of health care services and providers,” effective communications and care plan transitions (hand-offs) between providers, a focus on the patient’s needs, the communication of “clear and simple information that patients can understand,”<sup>18</sup> and the effective use of health information technologies.<sup>19</sup>

It is broadly recognized that many of the care coordination issues that present in the SUD context follow from the historic segregation of substance use diagnosis and treatment from mainstream healthcare delivery, with the former frequently thought of as social or criminal justice issues that should be dealt with by psychiatric hospitals or prisons.<sup>20</sup> As we now know, persons suffering from SUD (and frequent co-morbidities such as mental health diseases) are particularly vulnerable populations that in practice require additional and particularly robust levels of care coordination. These unmet needs likely are exacerbated when we combine additional co-morbidities associated with the near elderly and the elderly.

Hospital readmissions among the elderly is a useful proxy, with a higher rate of readmission among seniors with multiple symptoms such as cognitive impairment and polypharmacy.<sup>21</sup> Indeed the readmissions penalty program is an attempt to make hospitals commit to wraparound services including home visits to assist vulnerable populations.<sup>22</sup> Perhaps the best-known case

<sup>15</sup> See, e.g., *Improving Diagnosis in Health Care*, THE NATIONAL ACADEMIES OF SCIENCES ENGINEERING MEDICINE (Sept. 22, 2015), <http://www.nationalacademies.org/hmd/Reports/2015/Improving-Diagnosis-in-Healthcare.aspx>.

<sup>16</sup> *Care Coordination*, AGENCY FOR HEALTHCARE QUALITY AND RESEARCH, <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html> (last visited Mar. 30, 2018).

<sup>17</sup> *Care Coordination Measures*, NATIONAL QUALITY FORUM, <http://www.qualityforum.org/ProjectDescription.aspx?projectId=73700> (last visited Mar. 30, 2018).

<sup>18</sup> *What Is Care Coordination?*, NEJM CATALYST (Jan. 1, 2017), <https://catalyst.nejm.org/what-is-care-coordination/>.

<sup>19</sup> *Improved Care Coordination: The Need for Better Improved Care Coordination*, HEALTHIT.GOV, <https://www.healthit.gov/providers-professionals/improved-care-coordination> (last visited Mar. 30, 2018).

<sup>20</sup> *Health Care Systems And Substance Use Disorders*, in *FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH*, 6-1, 6-5 (2016), available at <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-general-report.pdf>.

<sup>21</sup> Raval, A. D., Zhou, S., Wei, W., Bhattacharjee, S., Miao, R., & Sambamoorthi, U. (2015). 30-Day Readmission Among Elderly Medicare Beneficiaries with Type 2 Diabetes. *Population Health Management*, 18(4), 256–264, <http://doi.org/10.1089/pop.2014.0116>.

<sup>22</sup> Joshua M. Liao et al, *Beyond Adjustments for Socioeconomic Status in Hospital Readmissions Penalties*, *Harv. Pub. H. Rev.* (2016), <http://harvardpublichealthreview.org/632/> (arguing hospitals should adopt “public health-minded organizational strategies” and commit “resources to out-of-hospital interventions” including food security and housing).

management/care coordination/wrap-around services model is that adopted by the Ryan White HIV/AIDS Program. The provision of medical case management, nonmedical case management, social services are key features of the program.<sup>23</sup> By filling gaps between existing services and because it is a “payer of last resort,” the program has been extremely successful in reducing AIDS-related mortality and morbidity.<sup>24</sup> It is a thoughtful model to follow any time we examine healthcare services for vulnerable populations.

## 2. Access

Our research in Indiana suggest that persons with SUD face acute problems in accessing healthcare services. Our state is not alone in facing inadequate treatment opportunities, both qualitative and quantitative. There are long waiting lists, a dearth of treatment availability in some rural areas (fewer than one in ten treatment facilities are in rural areas<sup>25</sup>) and quality issues caused, for example, by facilities being detox-only or not offering a full range of evidence-based medication assisted treatments.<sup>26</sup>

Approximately 23 per cent of the Medicaid population (or 15 million persons) are over 45 years of age.<sup>27</sup> CMS is highly supportive of state flexibility in Medicaid services and states are leveraging Section 1115 waiver authority to test innovations.<sup>28</sup> However, some recently approved waivers such as paperwork requirements for establishing eligibility and premium payments may disproportionately affect persons with SUD and co-morbidities.

More positively, Section 1115 waivers may be available to implement innovations in behavioral health such as suspending The Medicaid Institutions for Mental Disease (IMD) exclusion which disallows Medicaid funding of Medicaid coverage of specialized inpatient behavioral health services, reimbursing care coordination, or pay for services that address health-related social needs such as supportive housing, transportation and food.<sup>29</sup>

<sup>23</sup> HIV Care Providers Emphasize The Importance Of The Ryan White Program For Access To And Quality Of Care Neeraj Sood, et al, doi: 10.1377/hlthaff.2013.1297 HEALTH AFFAIRS 33, NO. 3 (2014): 394–400.

<sup>24</sup> Ryan White Part C Program: Providing Effective, Patient- Centered Medical Care to People Living with HIV/AIDS, 2014, [http://www.hivma.org/uploadedFiles/HIVMA/Policy\\_and\\_Advocacy/Ryan\\_White\\_Medical\\_Providers\\_Coalition/Comments/FY%2015%20Approps\\_Part%20C%20Paper\\_Final.pdf](http://www.hivma.org/uploadedFiles/HIVMA/Policy_and_Advocacy/Ryan_White_Medical_Providers_Coalition/Comments/FY%2015%20Approps_Part%20C%20Paper_Final.pdf)

<sup>25</sup> William F. Benson and Nancy Aldrich, Rural Older Adults Hit Hard By Opioid Epidemic, *Aging Today*, Sep. 27 2017, <http://www.asaging.org/blog/rural-older-adults-hit-hard-opioid-epidemic>.

<sup>26</sup> Knudsen, H. K., Abraham, A. J., & Oser, C. B. (2011). Barriers to the implementation of medication-assisted treatment for substance use disorders: The importance of funding policies and medical infrastructure. *Evaluation and Program Planning*, 34(4), 375–381. <http://doi.org/10.1016/j.evalprogplan.2011.02.004>; Brendan Saloner, Colleen L. Barry, Ending the Opioid Epidemic Requires a Historic Investment In Medication-Assisted Treatment, *Journal of Policy Analysis and Management*, 2018, <https://doi.org/10.1002/pam.22047>.

<sup>27</sup> KFF, Medicaid Enrollment by Age, <https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-age/>

<sup>28</sup> National Association of Medicaid Directors, Medicaid Section 1115 Waiver Trends in an Era of State Flexibility, Mar. 2018, <http://medicaiddirectors.org/wp-content/uploads/2018/03/Section-1115-Waiver-Trends-NAMD-Whitepaper-1.pdf>.

<sup>29</sup> Id.

### 3. Undertreatment

One of the frequent calls to action during the opioid crisis is to reduce overprescribing and overtreatment. However, as overtreatment is brought under control, the pendulum may well swing too far in the other direction. According to SAMHSA “Nearly half of older Americans suffer from a chronic pain disorder, and the incidence of chronic pain increases with age.”<sup>30</sup> Chronic pain becomes common after the age of 55 while joint pain increases exponentially thereafter.<sup>31</sup> Among the elderly, 50 percent of those who live independently and 75-85 percent in care facilities suffer from chronic pain. Even today, however, “pain among older adults is largely undertreated.”<sup>32</sup>

Denying prescription opioids to a cohort that suffers from chronic pain and, in the case of the elderly or near-elderly, has been treated for a decade or more with opioids could have serious consequences. In addition to undertreatment problems some in the cohort may turn to illicit drugs with all the negative public health connotations entailed.<sup>33</sup>

This delicate balance between overtreatment and undertreatment highlights both the need for careful calibration of interventions and reminds us that evidence-based SUD interventions resist a “one-size fits all” model.

### Conclusion

In preparing these remarks we found gaps in the data and relatively little evidence-based research discussing opioid misuse among elderly cohorts, suggesting that additional research is warranted. Once again I express my thanks to the Committee for this opportunity to address these vital issues. Going forward, I and other members of the Indiana University Grand Challenge team will be at your disposal.

<sup>30</sup> Opioid Use in the Older Adult Population, <https://www.samhsa.gov/capt/tools-capt-learning-resources/opioid-use-older-adult-population>

<sup>31</sup> Prevalence and Relevance of Pain in Older Persons, Stephen J. Gibson, PhD David Lussier, MD, FRCP Pain Medicine, Volume 13, Issue suppl\_2, 1 April 2012, Pages S23–S26, <https://doi.org/10.1111/j.1526-4637.2012.01349.x>

<sup>32</sup> Seniors and Chronic Pain, MedlinePlus, Fall 2011 Issue: Volume 6 Number 3 at 15, <https://medlineplus.gov/magazine/issues/fall11/articles/fall11pg15.html>

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