

THE HYDRA PARADOX OF THE OPIOID EPIDEMIC: WHY SUPPLY-SIDE RESPONSES WILL FUEL RATHER THAN CURB THE OPIOID EPIDEMIC

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The U.S. Department of Health and Human Services declared the opioid epidemic a public health emergency in 2017. While the total number of older adults misusing opioids may be less than other age groups, opioid misuse in older adults is still increasing. It is critical to account for the elderly when developing solutions to this tragic and nationwide epidemic. This Note investigates the potential impact of several of the initiatives set forth in the U.S. Centers for Medicare and Medicaid Services Roadmap. A comprehensive background will be provided on the United States' opioid epidemic, the epidemic's impact on senior citizens, as well as the basic structure of Medicare, which is essential for understanding how the U.S. Centers for Medicare and Medicaid Services is combatting this far-reaching epidemic. This Note then analyzes possible ways that the U.S. Centers for Medicare and Medicaid Services can implement its prevention initiatives, specifically focusing on the dangers of only relying on supply-side prevention. This Note recommends that the U.S. Centers for Medicare and Medicaid Services dedicates sufficient efforts toward alternative pain treatment methods, such as Medical Cannabis, and the continued use of federal grants to research possible treatment methods. Also, the U.S. Centers for Medicare and Medicaid Services should focus on treating the underlying substance abuse disorders that continue to drive and intensify the opioid epidemic. The utilization of medication-assisted treatment has proven to be fruitful, and the expansion of Medicare coverage for medication-assisted treatment should be a long-term goal.

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I. Introduction

In June 2015, an Indiana mother suffered the deaths of two sons in one night.¹ What was to blame for taking the lives of these teenage brothers after they had returned home, safe and sound, from high school graduation celebrations?² Opioids.³ In May 2018, news anchor Angela Kennecke worked on a story covering the opioid crisis.⁴ Just hours after speaking with three mothers who had experienced the wrenching loss of children to opioid overdoses, Angela was informed that her own daughter's life had been lost to a fatal overdose of fentanyl.⁵ These stories of young lives lost at the hands of opioid overdoses have become all too familiar. Yet, while much of the focus in the news coverage of the opioid crisis has been dedicated to stories of teenagers and young adults, one group also being impacted by the epidemic is often neglected: senior citizens.⁶

In 2017, the U.S. Department of Health and Human Services ("HHS") officially declared the United States' opioid epidemic a public health emergency.⁷ With over two million Americans suffering from an opioid use disorder ("OUD") and over 42,000 lives taken by opioid overdoses in 2016, this declaration by HHS came as no surprise.⁸ In July 2017, the Office of the Inspector General published an eye-opening re-

1. Ryan Bergeron, *Woman Lost 2 Sons in One Night to Opioids; Fighting the Crisis Is Now Her Life's Work*, CNN, Apr. 23, 2018, <https://www.cnn.com/2018/04/20/health/turning-points-becky-savage-opioids/index.html>.

2. *Id.*

3. *Id.*

4. Brett Molina, *She Reported on the Opioid Epidemic for Years. Then, Her Daughter Died of an Overdose*, USA TODAY, Sept. 11, 2018, <https://www.usatoday.com/story/news/nation-now/2018/09/11/angela-kennecke-reporter-shares-daughters-fatal-fentanyl-overdose/1264516002/>.

5. *Id.*

6. See Elise R. Friello, *A Growing Concern: Substance Use Disorders, Medication Misuse, and Older Adults*, 11 ALB. GOV'T L. REV. 1, at 10 (2018) [hereinafter Friello] ("[S]ubstance abuse is a problem affecting both the Baby Boomer generation and younger generations...."); Dana Schilling, *Senior Citizens and the Opioid Crisis*, 328 ELDER LAW ADVISORY NL 1, at 1 (2018) [hereinafter Schilling]; Mark Guydish, *Misericordia Teacher Testifies on Elder Opioid Abuse*, TIMES LEADER (May 25, 2018), <https://www.timesleader.com/news/705468/misericordia-teacher-testifies-on-elder-opioid-abuse> [hereinafter Guydish] ("The opioid epidemic has generated countless headlines and news stories, but Bill Stauffer believes an important part of the problem is being neglected: Misuse of the painkillers by older adults.").

7. *What Is the U.S. Opioid Epidemic?*, U.S. DEP'T OF HEALTH & HUMAN SERV., <https://www.hhs.gov/opioids/about-the-epidemic/index.html> (last visited Nov. 4, 2019).

8. See *id.*

port on the relationship between Medicare Part D and the opioid epidemic.⁹ According to the report, one-in-three Medicare Part D beneficiaries received a prescription opioid in 2016, with approximately 500,000 beneficiaries receiving high amounts of opioids.¹⁰ Further, while nearly 90,000 beneficiaries were found to be at serious risk of developing an opioid use disorder, about 400 prescribers were identified as practicing questionable opioid prescribing patterns for these beneficiaries at serious risk.¹¹

The Inspector General's report undoubtedly drew much-needed attention to the overlooked senior citizens and their struggles in the opioid epidemic. Less than a year later, the U.S. Centers for Medicare and Medicaid Services ("CMS") published a Roadmap outlining its plan of attack for addressing the opioid epidemic's impact on Medicare and Medicaid beneficiaries.¹² While some of the initiatives set forth in the Roadmap offer a glimmer of hope for Medicare beneficiaries in their fight against the opioid crisis, other initiatives should raise serious questions of just how impactful these actions will be in addressing opioid-related issues suffered by Medicare beneficiaries.¹³

This Note will examine the potential impact of several of the initiatives set forth in the CMS Roadmap. Part II will provide a comprehensive background on the United States' opioid epidemic, the epidemic's impact on senior citizens, as well as the basic structure of Medicare, which is essential for understanding the role of CMS in combatting this epidemic. Part III will analyze potential routes CMS may take to carry out its "prevention" initiatives, specifically focusing on the possible downfalls of overemphasis on supply-side prevention. A recommendation will then be provided in Part IV urging CMS to dedicate sufficient efforts toward alternative pain treatment methods and the treatment of OUDs.

9. U.S. DEP'T OF HEALTH & HUMAN SERVS., OFF. INSPECTOR GEN., OE1-02-17-00250, OPIOIDS IN MEDICARE PART D: CONCERNS ABOUT EXTREME USE AND QUESTIONABLE PRESCRIBING 1 (2017), <https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf> [hereinafter OPIOIDS IN MEDICARE PART D].

10. *Id.*

11. *Id.*

12. See U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., CMS ROADMAP TO ADDRESS THE OPIOID EPIDEMIC (2018), <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf> [hereinafter CMS ROADMAP].

13. See *id.*

II. Background

As of 2018, more than 115 lives are lost daily due to opioid overdoses in the United States.¹⁴ Opioids are not only accounting for large numbers of deaths, but they are also responsible for a substantial percentage of *all* drug overdoses, with three out of every five overdoses involving opioids.¹⁵ Before diving into how to best combat this crisis, it is important to understand how we got here in the first place. Part A of this section will provide an overview of the opioid epidemic, including a discussion of the classes of opioids and the changes in opioid prescribing behaviors that have occurred over time. Part B will summarize how the opioid epidemic specifically affects senior citizens. An overview of the four parts of Medicare will be set forth in Part C. This section will conclude with Part D, which will illustrate how Medicare is an important piece of the puzzle when addressing the opioid epidemic as it relates to senior citizens.

A. What is the Opioid Epidemic?

Opioids are substances that work in the nervous system of the body to reduce the intensity of pain.¹⁶ While opioids come in many forms, including prescription pain relievers, heroin, and synthetic opioids, all are chemically related and interact with opioid receptors on nerve cells.¹⁷ The euphoria produced by opioids may lead to misuse, and ultimately, addiction or dependence.¹⁸ Opioids have been recognized as a legitimate form of pain treatment;¹⁹ however, the prescribing of opioids is often pinned as the origin or catalyst of the opioid epidemic.²⁰

14. *Opioid Overdose Crisis*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis> (last visited Nov. 4, 2019) [hereinafter *Opioid Overdose Crisis*].

15. See *Overview of the Drug Overdose Epidemic: Behind the Numbers*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/index.html> (last visited Nov. 4, 2019) (stating two out of every three drug overdose deaths involve an opioid).

16. *Id.*

17. See *Opioids*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drugs-abuse/opioids#summary-of-the-issue> (last visited Nov. 4, 2019).

18. *Id.*

19. See *Prescription Opioids*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/drugfacts/prescription-opioids> (last visited Nov. 4, 2019).

20. See *Opioid Overdose Crisis*, *supra* note 14.

Relevant history regarding the current opioid epidemic may find its origin in the 1980s, a time known for “opiophobia.”²¹ Throughout the 1980s, physicians exhibited immense fear in prescribing opioids to patients, vastly impacting the standard of care for the treatment of pain.²² For example, a 1986 study found that “forty-five percent of patients in medical and surgical units of a large Midwestern medical center reported experiencing excruciating pain.”²³ Notably, less than half of those who reported experiencing pain in the study recall health professionals asking about pain levels.²⁴ The undertreatment of pain carried into the 1990s and played a crucial role in the spike of opioid prescribing and use.²⁵ In 1991, Dr. Mitchell Max wrote a piece, published in *Annals of Internal Medicine*, criticizing the medical field’s poor pain treatment methods and recommending changes, including increased attention to pain assessments and the use of opioids to treat pain.²⁶ Dr. Max’s work proved influential, as the American Pain Society released quality assurance standards for the relief of pain the following year, incorporating several of Dr. Max’s recommendations.²⁷ The U.S. Veterans Health Administration even went so far as to implement pain as a “fifth vital sign” approach.²⁸

Accompanying the issue of undertreating pain, and physicians’ increased priority to address the issue, were prescription opioid manufacturers who were actively working to reassure physicians of the

21. Michael Waldrop, *A Little Less Regulation: Why Federal Pain Management Laws are Hurting State Efforts to Combat the Opioid Epidemic*, 43 MITCHELL HAMLIN L. REV. 881, 891 (2017) [hereinafter Waldrop] (“A phenomenon occurred in clinics and hospitals across the country during the 1980s that had a huge effect on the standard of care for treating patient pain in the following decades. This phenomenon was called ‘opiophobia,’ which meant a physician’s fear to prescribe opioids—even in cases of terminal illness.”).

22. *Id.*

23. Ameet Sarpatwari et al., *The Opioid Epidemic: Fixing A Broken Pharmaceutical Market*, 11 HARV. L. & POL’Y REV. 463, 464 (2017) (citing Marilee Donovan et al., *Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients*, 30 PAIN 69, 71, 73 (1987)) [hereinafter Sarpatwari et al.].

24. *Id.* at 465.

25. *See id.* (“A consequence of opiophobia from the 1980s was an epidemic of pain undertreatment in the 1990s.”).

26. *See* David W. Baker, *The Joint Commission’s Pain Standards: Origins and Evolution*, JOINT COMM’N 2–3 (2017), https://www.jointcommission.org/assets/1/6/Pain_Std_History_Web_Version_05122017.pdf.

27. *See id.* at 3.

28. *See generally* U.S. DEP’T OF VETERANS AFFAIRS, PAIN AS THE 5TH VITAL SIGN TOOLKIT (2000), https://www.va.gov/PAINMANAGEMENT/docs/Pain_As_the_5th_Vital_Sign_Toolkit.pdf (discussing importance of treating pain and setting forth a toolkit for pain treatment).

safety of prescription opioids.²⁹ Additionally, the pharmaceutical industry introduced extended-release opioids, which were considered more efficient in treating pain because soothing effects were released slowly, rather than all at once.³⁰ These factors, taken together, created the perfect storm for a rapid increase in the prescribing of opioids, and in time, resulted in widespread misuse of opioids before the adverse effects became clear to medical professionals.³¹ Between 2000 and 2010, oral opioid prescriptions rose by 104%,³² and in most years between 1999 and 2014, prescription opioid deaths continued to increase.³³

Prescription opioids are only one component of the larger opioid epidemic, as heroin and synthetic opioids also play critical roles.³⁴ In 2016, nearly 948,000 people in the United States reported using heroin, and approximately 15,000 people died of heroin overdoses.³⁵ Synthetic opioids took the lives of over 19,000 people in the United States in 2016.³⁶ Interestingly, many overdose deaths originally thought to be prescription opioid deaths were later determined to be caused by illicit fentanyl and heroin, potentially pointing to a larger addiction problem.³⁷ Statistics suggest prescription pain relievers are often the first step in an individual's battle with opioid addiction, as it has been reported that up to eighty percent of people who use heroin first misused prescription opioids.³⁸ These statistics run the risk of generating a misguided belief that physicians are responsible for prescribing opioids to each of the individuals whose opioid addiction began with prescription

29. See *Opioid Overdose Crisis*, *supra* note 14 ("In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates.").

30. See Waldrop, *supra* note 21, at 891–92.

31. See *id.*

32. See Sarpatwari et al., *supra* note 23, at 464.

33. See Waldrop, *supra* note 21, at 893.

34. See *Opioid Overdose Crisis*, *supra* note 14.

35. See *Heroin Overdose Data*, U.S. CTRS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/heroin.html> (last visited Nov. 4, 2019).

36. See *Synthetic Opioid Overdose Data*, U.S. CTRS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/fentanyl.html> (last visited Nov. 4, 2019).

37. Manchikanti et al., *Reframing the Prevention Strategies of the Opioid Crisis: Focusing on Prescription Opioids, Fentanyl, and Heroin Epidemic*, 21 PAIN PHYSICIAN 309, 311 (2018) [hereinafter Manchikanti et al.] ("It is now known that many deaths due to illicit fentanyl and heroin have been counted as prescription opioid deaths because of the inability to separate fentanyl formulation and metabolites of heroin.").

38. See *Opioid Overdose Crisis*, *supra* note 14.

pain relievers.³⁹ Misused prescription opioids are often *nonmedical*, which includes the use of prescription pain relievers that were not prescribed by a doctor.⁴⁰ The ill-informed belief that physicians are the root cause of the opioid epidemic will play a role in establishing strategies to beat the opioid epidemic.

B. Senior Citizens and the Opioid Epidemic

Senior citizens are rarely the focal point in the opioid epidemic.⁴¹ Nonetheless, the opioid crisis has proven to have a devastating impact on this forgotten age group.⁴² Between 2006 and 2014, opioid-related emergency department visits among adults aged sixty-five and older more than doubled.⁴³ In 2014, adults aged sixty-five and over accounted for 36,776 opioid-related emergency department visits, and seventy percent of these visits resulted in hospital admission.⁴⁴ It is no secret that older adults are least likely to misuse opioids; however, while opioid misuse among young adults, the age group most likely to misuse opioids, declined between 2002 and 2014, opioid misuse in older adults is increasing.⁴⁵ While the total number of older adults misusing opioids is far less than the various other age groups, it is concerning to see misuse in older adults *increasing* as misuse in other age groups decreases.⁴⁶

39. See Pradip K. Muhuri et al., *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CBHSQ DATA REVIEW (Aug. 2013), <https://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm#endnote1>.

40. See *id.* (“NSDUH defines nonmedical use of prescription drugs as use of drugs that were not prescribed for the respondent or used only for the experience of feeling they caused.”).

41. Friello, *supra* note 6, at 10; Schilling, *supra* note 6, at 1; see Guldish, *supra* note 6.

42. See Friello, *supra* note 6, at 10 (“While trends indicate that substance abuse is a problem affecting both the Baby Boomer generation and younger generations . . .”).

43. Mary W. Carter, *The Hidden Epidemic: Opioid Addiction Among Older Adults*, 27 EXPERIENCE 1, 2 (2017) [hereinafter Carter].

44. *Id.*

45. See *Opioid Misuse Increases Among Older Adults*, SUBSTANCE ABUSE & MENTAL HEALTH ADMIN. (July 25, 2017), https://www.samhsa.gov/data/sites/default/files/report_3186/Spotlight-3186.html.

46. See *id.* (“Even though the proportion of older adults who misuse opioids is relatively small compared to young adults, the NSDUH data suggest opioid misuse is increasing among older adults.”).

1. SENIOR CITIZENS AND OPIOID RISK FACTORS

Several factors contribute to senior citizens' risk of OUDs and opioid overdose.⁴⁷ Senior citizens are highly susceptible to chronic pain, as almost half the older population reports suffering from chronic pain not related to cancer.⁴⁸ Many older adults also suffer from various chronic conditions, requiring the care of multiple physicians.⁴⁹ The end result is older adults receiving opioid prescriptions from multiple sources simultaneously.⁵⁰

Opioid prescribing for older adults may warrant a heightened level of attention due to the increased risks associated with opioid use by seniors.⁵¹ A 2017 study conducted by George Jay Unick and Daniel Ciccarone, of University of Maryland and University of California San Francisco respectively, examined the trends in prescription opioid overdose-related ("POD") hospitalizations and heroin overdose-related ("HOD") hospitalizations.⁵² In evaluating data from 2000 through 2014, Unick and Ciccarone noted that individuals between the ages of fifty-five and fifty-nine years old had "statistically significant higher increases in yearly rates of POD hospitalizations compared to those aged below fifty."⁵³ Younger individuals, on the other hand, exhibited statistically significant higher rates of HOD hospitalizations.⁵⁴

Moreover, Adam J. Rose, an Associate Professor of Medicine at Boston University, conducted a study evaluating the effects of age on

47. See Carter, *supra* note 43, at 2.

48. *Id.*

49. *Id.*

50. *Id.* ("Older adults are also more apt to suffer from multiple chronic conditions and, thus, are more likely to be under the care of several doctors. In addition, nearly 80 percent of older adults take at least one prescription daily, while 20 percent take five or more prescriptions each day.").

51. See generally Adam J. Rose et al., *Effects of Age on Opioid Prescribing, Overdose, and Mortality in Massachusetts, 2011 to 2015*, 67 J. AM. GERIATRICS SOC'Y 128 (2019) [hereinafter Rose et al.] (discussing increased risks associated with potentially inappropriate prescribing of opioids for older adults).

52. See George Jay Unick & Daniel Ciccarone, *U.S. Regional and Demographic Differences in Prescription Opioid and Heroin-Related Overdose Hospitalizations*, 46 INT'L J. DRUG POL'Y 112, 113-14 (2017).

53. *Id.* at 115 ("The rates of 25-29 year olds were statistically significantly higher compared with all groups except for 20-24 year olds. For example, between 2009 and 2010, 25-29 year olds had an increase of 1.03 HOD hospitalizations per 100,000, while 50-54 year olds had an increase of 0.49 HOD hospitalizations per 100,000.").

54. *Id.* ("For example, between 2009 and 2010, 25-29 year olds had an increase of 1.03 HOD hospitalizations per 100,000, while 50-54 year olds had an increase of 0.49 HOD hospitalizations per 100,000.").

the prospects of potentially inappropriate prescribing (“PIP”) of opioids, as well as how age effects the possibility of adverse outcomes resulting from PIP.⁵⁵ Rose found that age was overwhelmingly the strongest indicator of individuals undergoing PIP.⁵⁶ Further, Rose found that “PIP was strongly associated with higher odds of adverse events in older and younger adults.”⁵⁷ This is likely because older adults are especially vulnerable to the toxicity of opioids, especially when being given potentially inappropriate amounts.⁵⁸ These studies bring to light the potentially heightened dangers of opioid use by older adults and highlight precisely why older adults must not be neglected in the larger opioid epidemic conversation.

2. SENIOR CITIZENS ARE NOT IMMUNE FROM OPIOID ADDICTION

Oregon illustrates all too well how heavily the older population is being impacted by the opioid epidemic.⁵⁹ In the past decade, the rate of older people in Oregon being admitted to a hospital for opioid-related complications has tripled, and in 2015, the rate of elderly hospitalizations for opioid-related issues was 700 per 100,000 patients.⁶⁰ Some Oregon medical professionals, while aware of opioid abuse among the older population, were “startled” to learn of these statistics and the true prevalence of opioid abuse and disorders among older adults in Oregon.⁶¹ Public health officials of Oregon have focused on curbing opioid use as its primary method of countering the crisis.⁶²

55. Rose et al., *supra* note 51, at 128–29.

56. *Id.* at 129–30.

57. *Id.* at 130.

58. *Id.* at 128 (“Older adults may be particularly vulnerable to toxicity from PIP, given greater pharmacokinetic vulnerability inherent in the aging process.”).

59. See Lynne Terry, *Oregon Leads U.S. in Seniors Hospitalized for Opioids*, THE OREGONIAN, (July 7, 2017), https://www.oregonlive.com/health/index.ssf/2017/07/oregon_has_top_rate_in_us_of_s.html.

60. *See id.*

61. *See id.* (“Nemeth had no idea about the problem until contacted by The Oregonian/OregonLive. Startled to see the statistics, he talked to peers outside Providence. They had no clue either, he said.”).

62. *See id.* (“‘It appears that we are moving in the right direction but we’re not there yet,’ said Dr. Katrina Hedberg, the state epidemiologist and health officer. ‘We’re hoping that prescribing fewer opioids will lead to fewer people who are hospitalized.’”).

Sixty-year-old Jerry Hall began exhibiting signs of an OUD after being prescribed opioids for several health issues.⁶³ When Jerry's physicians developed concerns regarding Jerry's opioid use, he was placed on a monitoring program and given a lighter opioid prescription.⁶⁴ When Jerry ran out of his prescribed pills, he obtained pills from family and friends.⁶⁵ Jerry's physicians eventually became aware of his use of unprescribed opioids, causing the physicians to cut him off completely from prescription opioids, exacerbating his OUD, and leading him to spend copious amounts of money on illicit opioids.⁶⁶ Jerry's struggle illustrates the common features of the opioid epidemic, and demonstrates not only the risk of older adults developing OUDs, but also the potential downfalls of responding to a developed case of OUD by merely cutting off medical opioid supplies.

C. Basics of Medicare

Medicare is a federal health insurance program.⁶⁷ Generally, an individual may be eligible for Medicare if he or she is sixty-five or older or suffers from a qualifying disability or medical condition.⁶⁸ Medicare is broken down into four basic parts:⁶⁹ (1) Part A is hospital coverage, (2) Part B is general medical coverage, (3) Part C, known as Medicare Advantage, combines Parts A and B into one plan, and (4) Part D is prescription drug coverage.⁷⁰ Medicare, like private health insurance, is not free, meaning Medicare simply helps pay for medical services.⁷¹ Like other insurance plans, members are required to pay premiums, deductibles, co-payments, and/or co-insurance, depending on a variety of factors.⁷² CMS is the government entity, contained within HHS, that

63. *See id.* (“[H]e started relying on prescription medication for chronic pain but slowly slid into addiction.”).

64. *See id.*

65. *See id.*

66. *See id.* (“He paid his rent and fed his cats. He spent all the rest on opioids, even eating from food pantries.”).

67. *See What's Medicare?*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare> (last visited Nov. 4, 2019).

68. *See Who Can Get Medicare*, UNITED HEALTHCARE, <https://www.medicare-madeclar.com/basics/medicare-eligibility> (last visited Nov. 4, 2019).

69. *See id.*

70. *See id.*

71. *See id.*

72. *See id.*

is responsible for running both Medicare and Medicaid.⁷³ According to CMS program data, there are 59.1 million Medicare Part A and/or B beneficiaries, 50.3 million of which obtained eligibility due to age.⁷⁴ Part D, the focus of the Inspector General's report, has a total of 43.8 million beneficiaries.⁷⁵

D. How Is Medicare Relevant in the Opioid Crisis?

In publishing its Roadmap for combatting the opioid epidemic in 2018, CMS recognized the prevalence of opioid misuse amongst its beneficiaries, with six out of every 1000 Medicare beneficiaries suffering from an OUD.⁷⁶ CMS has been active in attempting to combat the opioid epidemic by initiating action well before the Inspector General's report regarding Medicare Part D.⁷⁷ In 2013, CMS implemented its opioid overutilization policy, setting forth point-of-sales controls, improved retrospective drug utilization review for identifying high risk beneficiaries, case management with prescribers, and data sharing between Part D sponsors.⁷⁸

Later, in January 2017, CMS published an Opioid Misuse Strategy, identifying four primary areas of focus.⁷⁹ This strategy, while including supply-side and prescribing-focused priorities, also established the need to treat OUDs and called for the increased use of "evidence-based" practices for pain management.⁸⁰ As part of explaining their

73. See *About CMS*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/About-CMS/About-CMS.html> (last visited Nov. 4, 2019).

74. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., CMS FAST FACTS 1 (July 2018), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html> [hereinafter CMS FAST FACTS].

75. *Id.*

76. See *CMS Opioid Roadmap*, CTRS. FOR MEDICARE & MEDICAID SERVS.: BLOG (June 11, 2018), <https://www.cms.gov/blog/cms-opioids-roadmap>.

77. See generally U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) OPIOID MISUSE STRATEGY 2016 1 (2017), <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf> [hereinafter OPIOID MISUSE STRATEGY 2016] (discussing strategies in 2016 for combatting the opioid crisis, specifically as it impacts Medicare and Medicaid beneficiaries).

78. See *Medicare Part D Overutilization Monitoring System (OMS) Summary*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (NOV. 3, 2015), <https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-overutilization-monitoring-system-oms-summary> [hereinafter *Medicare Part D OMS Summary*].

79. See OPIOID MISUSE STRATEGY 2016, *supra* note 77, at 2.

80. *Id.*

strategy, CMS recognized that the Medicare population has “among the highest and fastest-growing rates of diagnosed opioid use disorder.”⁸¹

The CDC’s annual surveillance reports on drug abuse in the United States lends additional support that Medicare plays a significant role in the opioid epidemic.⁸² In 2014, of all primary payers, Medicare accounted for the most beneficiaries hospitalized for opioid poisonings with 20,185 of the 53,000 total hospitalizations.⁸³ A year later, Medicare was again the payer with the most beneficiaries hospitalized for opioid poisonings, as the number jumped to 28,490 of the total 78,840 opioid poisoning hospitalizations.⁸⁴ Considering Medicare provides medical coverage for over fifty million individuals aged sixty-five and over and prescription drug coverage for over forty-three million Americans, the Medicare population is proven to have a large and growing population with OUDs, and Medicare continues to be the primary payer with the largest number of beneficiaries accounting for opioid poisoning hospitalizations.⁸⁵ It is clear Medicare and CMS play pivotal roles in addressing the opioid epidemic.⁸⁶

III. Analysis

The opioid epidemic is a complex problem, for which a simple solution will not suffice.⁸⁷ One go-to “solution” is supply-side prevention, which entails limiting the number of opioid prescriptions, as well as limiting the quantity of opioids provided in every prescription.⁸⁸ The

81. *Id.*

82. See U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, 2018 ANNUAL SURVEILLANCE REPORT OF DRUG-RELATED RISKS AND OUTCOMES 6 (2018), <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf> [hereinafter 2018 ANNUAL SURVEILLANCE REPORT]; U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, ANNUAL SURVEILLANCE REPORT OF DRUG-RELATED RISKS AND OUTCOMES 60 (2017), <https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf> [hereinafter 2017 ANNUAL SURVEILLANCE REPORT].

83. See 2017 ANNUAL SURVEILLANCE REPORT, *supra* note 82, at 59.

84. See 2018 ANNUAL SURVEILLANCE REPORT, *supra* note 82, at 63.

85. See Marian E. Gornick et al., *Thirty Years of Medicare: Impact on the Covered Population*, 18 HEALTH CARE FIN. REV. 179 (1996); Cf CMS FAST FACTS, *supra* note 74.

86. See *id.*; CMS FAST FACTS, *supra* note 74, at 1.

87. See Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality*, 15 IND. HEALTH L. REV. 139, 163 (2018) [hereinafter Beletsky].

88. See *id.*

CMS Roadmap places strong emphasis on cutting down opioid prescriptions to prevent the development of OUDs.⁸⁹ Given the nature of the Inspector General's report, it is not surprising that CMS has taken this position,⁹⁰ however, overemphasis on limiting opioid prescriptions may not prove to be as impactful as one may hope.⁹¹

A. Opioid Prescribing Behaviors Have Improved, Yet Opioid Disorders and Overdoses Continue to Increase

Opioid prescribing rates experienced a phase of dramatic increase beginning in the 1990s.⁹² That phase peaked in 2012 and has since been on the decline.⁹³ In 2017, the opioid prescribing rate was the lowest it had been in over ten years, yet the statistics regarding OUDs and opioid overdoses have continued to climb in the opposite direction.⁹⁴ Annual opioid prescribing rates have decreased at an average of 8.2% annually from 2014 to 2017,⁹⁵ yet this decline in opioid prescriptions is not being met with declining rates of opioid abuse and overdoses.⁹⁶

By way of example, in 2015, there were a reported 33,091 opioid-related overdose deaths, with 15,281 of those deaths resulting from prescription opioids.⁹⁷ Comparing those numbers to 2016, as opioid prescribing rates continued to decrease, there were a reported 42,249 opioid-related overdose deaths, with prescription opioids responsible for

89. See CMS ROADMAP, *supra* note 12, at 3 (describing prevention plans as reducing overprescribed opioids through lock-in programs, "real-time prescription controls with the use of prescription databases and point of sale pharmacy edits," establishing pharmacy protocols, monitoring systematic overprescribing, and incorporating incentives for appropriate prescribing).

90. See OPIOIDS IN MEDICARE PART D, *supra* note 9, at 1-2.

91. See Beletsky, *supra* note 87, at 163.

92. See Sarpatwari et al., *supra* note 23, at 464.

93. See U.S. Opioid Prescribing Rates Maps, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/maps/txrate-maps.html> (last visited Nov. 4, 2019) ("After a steady increase in the overall national opioid prescribing rate starting in 2006, the total number of prescriptions dispensed peaked in 2012 at more than 255 million and a prescribing rate of 81.3 prescriptions per 100 persons.").

94. See *id.*; Opioid Data Analysis and Resources, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/analysis.html> (last visited Nov. 4, 2019).

95. See 2018 ANNUAL SURVEILLANCE REPORT, *supra* note 82, at 6.

96. Manchikanti et al., *supra* note 37, at 311 ("However, the decline in opioid prescription rate is not accompanied by a correlating decline in opioid abuse and death rate.").

97. See 2017 ANNUAL SURVEILLANCE REPORT, *supra* note 82, at 60.

17,087 of the deaths.⁹⁸ These numbers indicate there are factors beyond opioid prescribing at play in the epidemic today.

B. Prescription Drug Monitoring Programs: Are These Really a Great Idea?

The CMS Roadmap, while emphasizing the need to limit opioid prescriptions in an effort to decrease the occurrences of OUDs and overdoses, does not provide detailed plans for how this might be accomplished.⁹⁹ One common method that has been employed for this exact purpose has been the use of a prescription drug monitoring program (“PDMP”).¹⁰⁰ A PDMP tracks the prescriptions of controlled substances via an electronic database.¹⁰¹ PDMPs provide “real-time” data, allowing providers to review prescribing histories of patients when deciding whether to prescribe the patient an opioid.¹⁰²

These programs are implemented and managed locally by the states, and as of 2019, forty-nine states have enacted legislation authorizing the creation and utilization of PDMPs.¹⁰³ The CMS Roadmap does not explicitly mention the use of a PDMP; however, it does set forth “strengthening real-time prescription controls with the use of prescription databases and point of sale pharmacy edits.”¹⁰⁴ CMS implemented the Overutilization Monitoring System (“OMS”) in 2013, which serves a similar purpose of tracking opioid prescriptions and identifying high risk beneficiaries, further evidencing CMS’s focus on supply-side prevention through the use of electronic database-type methods.¹⁰⁵

98. See 2018 ANNUAL SURVEILLANCE REPORT, *supra* note 82, at 65, 67.

99. See CMS ROADMAP, *supra* note 12, at 3.

100. See Beletsky, *supra* note 87, at 140.

101. See *What States Need to Know About PDMPs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/pdmp/states.html> (last visited Nov. 4, 2019).

102. See *id.*

103. See *Prescription Drug Monitoring Frequently Asked Questions (FAQ)*, PRESCRIPTION DRUG MONITORING PROGRAM TRAINING & TECH. ASSISTANCE CTR., <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq> (last visited Nov. 4, 2019).

104. See CMS ROADMAP, *supra* note 12, at 1–4.

105. See *Medicare Part D OMS Summary*, *supra* note 78.

1. TRACK RECORD OF PDMPs

The success of PDMPs has largely focused on the statistics surrounding the suppression of opioid medication supply.¹⁰⁶ Put simply, touting the success of PDMPs overemphasizes decreases in the number of opioid prescriptions supplied, while failing to examine “more meaningful metrics anchored to reducing risky drug use and overdose.”¹⁰⁷ For example, a study conducted by Erin L. Winstanley, Associate Professor at West Virginia University Medicine Rockefeller Neuroscience Institute, examined the effectiveness of PDMPs, focusing solely on the change in prescribing behaviors while neglecting other important indicators of improvements in the opioid epidemic, such as occurrences of misuse, disorders, or overdoses.¹⁰⁸

Undoubtedly, the precise goal of this study was to examine changes in prescribing behaviors; problematically, this demonstrates the arguable tunnel-vision that is apparent in the advocacy for PDMPs.¹⁰⁹ Taking into account previously discussed statistics regarding the drop in opioid prescriptions in the past several years, increases in opioid misuse, disorders, and overdoses, suggests that advocating for PDMPs as a means of fighting the epidemic may be premature or misguided.¹¹⁰

Evaluating the pattern of opioid epidemic indicators in states which have implemented PDMPs illuminates how PDMPs may not be accomplishing what has been claimed or expected. Wisconsin deployed its state PDMP in 2013.¹¹¹ In February 2017, then Governor Scott Walker flaunted the success of Wisconsin’s drug monitoring program.¹¹² The

106. See Beletsky, *supra* note 87, at 141–42.

107. *Id.*

108. See Erin L. Winstanley et al., *Mandatory review of a prescription drug monitoring program and impact on opioid and benzodiazepine dispensing*, 188 J. DRUG & ALCOHOL DEPENDENCE 169 (2018) [hereinafter Winstanley et al.].

109. See *id.*

110. See U.S. Opioid Prescribing Rates Maps, CTNS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Nov. 4, 2019); 2018 ANNUAL SURVEILLANCE REPORT, *supra* note 82; 2017 ANNUAL SURVEILLANCE REPORT, *supra* note 82.

111. See *PDMP Report Shows Continued Decline in Controlled Substances Dispensed*, ADVOCATE (July 31, 2018), https://walker.wi.gov/press-releases/pdmp-report-shows-continued-decline-controlled-substances-dispensed/article_738d5280-94bc-11e8-837d-ff8fc99e3e02.html.

112. See *Wisconsin Touts Successful Prescription Monitoring Program*, OCCUPATIONAL HEALTH & SAFETY (Feb. 10, 2017), <https://ohsonline.com/articles/2017/02/10/wisconsin-touts-successful-prescription-monitoring-program.aspx> [hereinafter *Wisconsin Touts Successful Prescription Monitoring Program*].

metrics he relied on in detailing his state's success were conveniently and exclusively limited to the decreased number of opioid prescriptions prescribed by physicians and ignored any mention of Wisconsin's opioid misuse or overdose statistics.¹¹³ Despite the state's PDMP decreasing the number of opioid prescriptions, Wisconsin's opioid-related overdose rate increased every year since the implementation of the PDMP, which may display the problems with focusing on supply-side prevention.¹¹⁴ In 2013, the state's opioid-related overdose rate was recorded at 10.6 deaths per 100,000 persons, and by 2016, that rate had climbed to 15.8 deaths per 100,000 persons.¹¹⁵

An examination of opioid-related deaths in Wisconsin between 2013 and 2016, specifically evaluating the numbers of deaths caused by each opioid type (prescription, heroin, and synthetic), raises serious doubts about the efficacy of cutting off medically prescribed opioids. In Wisconsin, prescription opioid overdose deaths increased from 285 deaths in 2010 to 382 deaths in 2016, heroin overdose deaths increased from ninety-two deaths in 2010 to 389 deaths in 2016, and synthetic opioids took the lives of sixty-six people in 2010, increasing to 288 in 2016.¹¹⁶ Prescription opioid deaths even decreased from 2014 to 2015 before increasing again in 2016.¹¹⁷ Heroin and synthetic opioid overdoses, on the other hand, increased every year, and both experienced significant jumps from 2015 to 2016—much like the spike in prescription opioid overdose deaths in 2016.¹¹⁸ If the state's PDMP is as successful as former Governor Walker exclaimed,¹¹⁹ then why are opioid-related overdose deaths, heroin deaths, and synthetic opioid-related deaths all increasing at significantly higher rates?¹²⁰ Wisconsin serves as a prime example of a state that has implemented a PDMP, successfully decreasing the number of opioid prescriptions supplied by physicians, yet has not experienced improvements in other important opioid epidemic indicators.

113. *See id.*

114. *See Wisconsin Opioid Summary*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/wisconsin-opioid-summary> (last visited Nov. 4, 2019) [hereinafter *Wisconsin Opioid Summary*].

115. *See id.*

116. *Id.*

117. *Id.*

118. *Id.*

119. *See Wisconsin Touts Successful Prescription Monitoring Program*, *supra* note 112 (“This report indicates our efforts throughout Wisconsin to fight prescription drug abuse and misuse are working,” Gov. Scott Walker said.”).

120. *See Wisconsin Opioid Summary*, *supra* note 114.

On the contrary, studies that are more critical of the use of PDMPs include more extensive analysis of the relationship between the implementation of state PDMPs and the rates of opioid-related issues such as misuse, disorders, and overdoses.¹²¹ A 2017 study conducted by Richard Brown, Attending Psychiatrist within the Bassett Healthcare Network in New York, examined the changes in opioid prescribing behaviors and overdose morbidity after the implementation of a New York state law, known as I-STOP, which requires clinicians to consult the state PDMP prior to prescribing opioids.¹²² The first notable finding was prescription opioid overdoses did level off following the PDMP implementation, but the alteration was considered “an insignificant change from the time period preceding the implementation of I-STOP.”¹²³ Heroin morbidity still saw a dramatic increase.¹²⁴

Similarly, Thomas C. Buchmueller, Professor and Chair of Business Economics and Public Policy at University of Michigan Ross School of Business, and Colleen Carey, Assistant Professor at Cornell University College of Human Ecology, conducted a 2018 study which evaluated the effect of state PDMP use on opioid utilization in Medicare, identifying similar concerns regarding the effect of PDMPs on issues such as opioid poisoning incidents.¹²⁵ It found that states requiring provider consultation of PDMPs, known as “must access” PDMPs, experienced positive impacts in curbing certain “extreme utilization” indicators, such as excessive quantities and doctor-shopping, but there was no significant effect on opioid poisoning incidents, indicating that substance use disorders persist despite the implementation of a PDMP.¹²⁶

121. See generally Richard Brown et al., *Impact of New York Prescription Drug Monitoring Program, I-STOP, on Statewide Overdose Morbidity*, 178 J. DRUG & ALCOHOL DEPENDENCE 348 (2017) (finding an increase in illicit drug, specifically heroin, deaths following the mandatory implementation of New York’s state Prescription Drug Monitoring Program).

122. *Id.* at 350.

123. *Id.*

124. *Id.*

125. See Thomas C. Buchmueller & Colleen Carey, *The Effect of Prescription Drug Monitoring Programs on Opioid Utilization in Medicare*, 10 AM. ECON. J. & ECON. POLICY 77 (2018) (examining impact of New York’s I-STOP law on opioid utilization in Medicare).

126. *Id.* at 108–09.

2. CMS OVERUTILIZATION MONITORING SYSTEM

PDMPs are just one example of a supply-side prevention tactic, but through analysis of the effectiveness, or lack thereof, of PDMPs' impact on opioid misuse and overdoses prominently displays concerns surrounding supply-side prevention focus. Even though CMS may or may not push for a national PDMP, or strengthened state laws for individual states' PDMPs, CMS has identified supply-side prevention and decreases in opioid prescriptions as an important prong in its plan to combat the opioid epidemic.¹²⁷ In fact, CMS has already implemented such a program with its OMS. The OMS was implemented to oversee Medicare Part D sponsors' compliance with CMS' opioid overutilization policy.¹²⁸ Sponsors are provided with a quarterly report, via the OMS, flagging high-risk beneficiaries and requiring sponsors to review each case, as well as follow up with CMS on how each case was handled.¹²⁹

According to CMS's report on the potential impact of the OMS on opioid overutilization by Medicare Part D beneficiaries, between 2011 and 2014, the percentage of beneficiaries enrolled in Part D utilizing opioids dropped from 31.9% in 2011 to 30.8% in 2014.¹³⁰ Nowhere did this brief report discuss trends regarding other opioid epidemic indicators; the sole emphasis was on opioid prescription statistics.¹³¹

3. WHAT FOLLOWS WHEN OPIOID PRESCRIPTIONS ARE CUT-OFF?

Addressing patient responses and behaviors when access to prescription opioids is cut off is key.¹³² There is evidence suggesting that patients, when faced with reduced ability to access licit opioids, may turn to illicit heroin, morphine, or fentanyl as alternatives, with studies indicating an increase in related mortality in some PDMP states.¹³³ As previously established, senior citizens are a group proven to be vulnerable to factors contributing to OUDs.¹³⁴ Most notably, senior citizens are

127. See CMS ROADMAP, *supra* note 12, at 3.

128. See Medicare Part D OMS Summary, *supra* note 78.

129. See *id.*

130. See *id.*

131. See *id.*

132. See Beletsky, *supra* note 87, at 162.

133. See *id.*

134. See Carter, *supra* note 43, at 2.

likely to suffer from ailments legitimately requiring effective pain treatment.¹³⁵ In some cases, the legitimate pain treatment method may in fact be an opioid.¹³⁶ Failing to treat senior citizens' pain may not only increase the chances of senior citizens tracking down non-medical, illegal opioids for the purposes of remedying pain, but may take an extensive emotional toll on seniors.¹³⁷

The issue of patients turning to illicit opioids is concerning considering the increased dangers associated with these drugs. While medically prescribed prescription opioids are given to patients directly from pharmacies, providing an element of certainty regarding what exactly the chemical make-up of the drug is, illicit "street" drugs do not carry the same assurance.¹³⁸ In recent years, there have been countless news stories on the increased presence of dangerous levels of fentanyl in illicit opioids, often linked to overdose deaths of individuals believing they were taking pure heroin or prescription drugs, such as hydrocodone, but were actually taking a drug that had been cut with lethal levels of fentanyl.¹³⁹ The clear dangers of illicit opioids, combined with the trend of turning to illicit opioids when access to medically prescribed prescription opioids are cut off, heightens concerns associated with simply turning to supply-side prevention tactics while leaving legitimate pain conditions and substance-abuse disorders untreated.

135. See *id.* at 2 ("Chronic pain is common among older adults, with nearly half of the older population reporting chronic, non-cancer-related pain.").

136. See generally U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN (2016), https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf (providing a guideline for appropriate opioid prescribing behaviors).

137. See *id.*

138. See Roger Collier, *Street versions of opioids more potent and dangerous*, 185 CANADIAN MED. ASS'N J. 1027, 1027 (2013) ("The many unknowns surrounding these pills and powders make them far more dangerous than those produced by pharmaceutical companies. Though the diversion of drugs from the medical system to the streets is a serious problem, people who misuse legitimate medications at least know what they are putting in their bodies.").

139. See Fiza Pirani, *What Is Fentanyl? 10 Things to Know About Fentanyl, the Potentially Deadly Drug*, THE ATLANTA J.-CONST. (Jan. 28, 2019), <https://www.ajc.com/news/health-med-fit-science/what-fentanyl-things-know-about-the-potentially-deadly-drug/qOcUSQkagnlhaUnwHchJ4l/> ("Because fentanyl is so highly potent, drug dealers have increasingly been mixing heroin, oxycodone or Xanax with fentanyl, deceiving buyers who are unaware that a powder or pill contains the drug."); Dennis Romero, *One Dead, 12 Hospitalized in Mass Overdose in California*, NBC NEWS (Jan. 12, 2019, 10:05 PM), <https://www.nbcnews.com/news/us-news/one-dead-12-hospitalized-mass-overdose-california-n958086> (reporting on the deaths and hospitalizations of individuals who had overdosed on fentanyl, likely mixed with heroin).

4. FINAL THOUGHTS ON PDMPs

This criticism directed toward the use of PDMPs is not intended to suggest that PDMPs have no place in the larger scheme for combating the opioid epidemic. Rather, the intention is to show the limitations of PDMPs to further drive home the point that overemphasis on supply-side prevention will not suffice in fighting the opioid epidemic. While PDMPs may serve the purpose of monitoring physician prescribing and *potentially* reducing the occurrences of new cases of OUDs,¹⁴⁰ this is a shortsighted view into the complex issues driving the epidemic. The evaluation and criticism of PDMPs is intended to serve as a vehicle for exposing the downfalls of expecting supply-side prevention to do much of the “heavy lifting” in countering the epidemic. While there may be other methods employed targeting supply-side prevention, PDMPs are the go-to route.

B. Lock-In Programs

The CMS Roadmap mentions the use of lock-in programs (“LIP”) as an additional measure to combat the opioid crisis.¹⁴¹ LIPs identify high-risk beneficiaries and limit their access to one provider and one pharmacy for opioid coverage.¹⁴² LIPs have historically been implemented in state Medicaid programs, thus the specifics of LIPs, such as when a beneficiary will be deemed high-risk and eligible for the LIP, vary state-to-state.¹⁴³ The Comprehensive Addiction and Recovery Act (“CARA”), passed in July 2016, created the initiative to implement an LIP, which went into effect in January 2019, in Medicare Part D prescription drug plans.¹⁴⁴

Several goals are associated with LIPs, including decreasing fraud, waste, and abuse of benefit plan (i.e. Medicaid) resources, reducing dangerous opioid use, and improving the care of high-risk beneficiaries.¹⁴⁵ Originally, the primary goal of LIPs was limiting fraud and

140. See generally Winstanley et al., *supra* note 108 (discussing PDMPs’ positive impact on physician opioid prescribing behaviors).

141. See CMS ROADMAP, *supra* note 12, at 3.

142. See Andrew W. Roberts, Walid F. Gellad & Ashley Cockerell Skinner, *Lock-In Programs and the Opioid Epidemic: A Call for Evidence*, 106 AM. J. PUB. HEALTH 1918, 1918 (2016).

143. See *id.* (For example, in North Carolina a beneficiary will be considered high-risk and eligible for LIP if he/she has more than six opioid claims or use more than three unique opioid prescribers in two months).

144. See *id.*

145. See *id.*

waste of resources.¹⁴⁶ As a result, most research evaluating the effectiveness of LIPs has focused on those goals mentioned with very little information available on the effectiveness of LIPs in reducing troublesome opioid use or improving the care of high-risk beneficiaries.¹⁴⁷

Rebecca B. Naumann, an assistant professor in the Department of Epidemiology and core faculty member of the Injury Research Prevention Center at University of North Carolina Chapel Hill, conducted a study evaluating North Carolina's Medicaid LIP's impact on the dispensing of controlled substances to Medicaid beneficiaries enrolled in the twelve-month LIP.¹⁴⁸ While the numbers of dispensed controlled substances during the lock-in decreased, beneficiaries' average daily morphine milligram equivalents of opioids increased.¹⁴⁹ An evaluation of the payer source revealed an increase in beneficiaries resorting to non-Medicaid payment sources, such as paying out-of-pocket.¹⁵⁰

The results of Naumann's study not only cast a shadow of doubt on the effectiveness of reducing opioid prescription with LIPs, but the study further indicates that attempts to limit or suppress an individual's access to opioids will not inevitably decrease or eliminate opioid use or misuse. While CMS ultimately did not have the option to opt out of implementing the LIP in Medicare Part D, as the LIP was established as a component of CARA, CMS must recognize not only the potential of beneficiaries resorting to other methods of payment to maintain their opioid supplies, but also the lacking evidence of LIPs' effectiveness in battling the opioid epidemic by reducing dangerous opioid use.

C. Let's Not Forget About the Fifty-Five to Sixty-Four Age Group

Much of the focus regarding Medicare logically centers on the sixty-five and over age group. Nevertheless, it is important to give attention to the age group that will be eligible for Medicare in upcoming

146. See Rebecca B. Naumann et al., *Evaluating Short- and Long-Term Impacts of a Medicaid "Lock-in" Program on Opioid and Benzodiazepine Prescriptions Dispensed to Beneficiaries*, 182 DRUG & ALCOHOL DEPENDENCE 112, 112 (2018).

147. See *id.* at 113.

148. *Id.*

149. *Id.* at 116 ("The average daily MME of opioids dispensed to beneficiaries was elevated during lock-in and post-release relative to pre-spike (daily mean difference per person: 18.7; 95% CI: 13.9, 23.6 and 11.1; 95% CI: 5.1, 17.1, respectively).").

150. *Id.* ("Compared to the pre-spike period, 6.6 (95% CI: 4.8, 8.5) more average daily MMEs per person were purchased using non-Medicaid payment during lock-in and 6.2 (95% CI: 3.7, 8.6) more post-release.").

years: the fifty-five to sixty-four-year olds. While opioid misuse and overdose statistics for the sixty-five and over group may be glossed over as fairly insignificant, especially when compared to the younger age groups being hit hardest by the epidemic, the same cannot be said for this fifty-five to sixty-four age group that could be enrolling in Medicare in upcoming years.

Statistics relating to current and ongoing OUDs may be even more troubling when giving thought to who will be enrolling in Medicare in the upcoming years. In 2015, while the sixty-five and older group accounted for 1188 opioid-related overdose deaths, the fifty-five to sixty-four age group experienced 5089 opioid-related overdose deaths.¹⁵¹ This statistic increased for both age groups in 2016, and again, the fifty-five to sixty-four age group suffered far more deaths at 10,632 compared to the sixty-five and older age group's 3075.¹⁵² In 2016, the fifty-five to sixty-four age group experienced the following: 1317 individuals with self-reported opioid drug use or prescription opioid drug misuse,¹⁵³ 17,305 opioid-related hospitalizations (the highest of any age group reported),¹⁵⁴ and 11,615 opioid-related emergency department visits.¹⁵⁵ These figures clearly illustrate how severely the fifty-five to sixty-four age group—consisting of individuals that will likely be enrolling in Medicare in the upcoming years—is feeling the effects of the opioid crisis.

The increased presence and use of naloxone may also play a role in increasing the number of beneficiaries enrolling in Medicare with an established OUD. Naloxone is a medication used to swiftly counteract an opioid overdose, available in injectable and nasal spray forms.¹⁵⁶ The injectable forms of naloxone are often carried by hospital emergency departments, as well as emergency first responders such as paramedics.¹⁵⁷ Narcan, a brand of naloxone nasal spray, as well as auto-injectable forms of naloxone, may also be available for purchase without a

151. 2017 ANNUAL SURVEILLANCE REPORT, *supra* note 82, at 60.

152. 2018 ANNUAL SURVEILLANCE REPORT, *supra* note 82, at 65.

153. *Id.* at 53.

154. *Id.* at 59.

155. *Id.* at 61.

156. *Opioid Overdose Reversal with Naloxone (Narcan, Evzio)*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio> (last visited Nov. 4, 2019).

157. *Id.*

prescription depending on state regulations.¹⁵⁸ Between 1996 and 2014, at least 26,500 opioid overdoses were reversed through the use of naloxone, showing naloxone's potential effectiveness in preventing opioid overdose deaths.¹⁵⁹ As the chances of surviving an opioid overdose increase, thanks to life-saving measures like naloxone, individuals with OUDs now have the ability to live longer. Those who were previously falling victim to opioid overdose deaths prior to reaching the age of eligibility for Medicare may now live to see sixty-five, resulting in more Medicare beneficiaries enrolling with already well-developed OUDs.

Examining the sixty-five and older Medicare population already suffering from OUDs, it is reasonable to say it is seemingly inevitable that a substantial number of future Medicare beneficiaries will enroll with already well-developed OUDs. Cutting off prescription opioid supplies is not going to resolve underlying addiction or misuse issues.¹⁶⁰ As CMS continues to work through its plan for curbing the opioid epidemic, including implementing the strategies set forth in the 2018 Roadmap, CMS must consider the individuals who will be enrolling in Medicare already suffering from an OUD. For these beneficiaries, supply-side measures limiting opioid prescriptions will not solve the problem.

D. 2018 SUPPORT Act

In October 2018, President Trump signed into law the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, also known as SUPPORT.¹⁶¹ SUPPORT amends a plethora of Medicare provisions,¹⁶² requiring the implementation of nine strategies to hopefully yield impactful results

158. *Id.*; *Naloxone*, CVS PHARMACY, <https://www.cvs.com/content/prescription-drug-abuse/save-a-life> (last visited Nov. 4, 2019).

159. *Naloxone for Opioid Overdose: Life-Saving Science*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/naloxone-opioid-overdose-life-saving-science/naloxone-opioid-overdose-life-saving-science> (last visited Nov. 4, 2019).

160. See Beletsky, *supra* note 87, at 163 (“[A]ddiction does not simply go away when the pills do . . .”).

161. See Maegan Vazquez, *Trump signs opioids law at White House event*, CNN (Oct. 24, 2018, 3:39 PM), <https://www.cnn.com/2018/10/24/politics/donald-trump-opioid-crisis-one-year-later-event/index.html>.

162. See Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018) [hereinafter SUPPORT Act].

in reversing the opioid crisis.¹⁶³ The first action required by SUPPORT is the expansion of substance abuse telehealth treatment services.¹⁶⁴ Telehealth services utilize “interactive audio and video telecommunications system that permits real-time communication” between a physician and beneficiary.¹⁶⁵ Next, SUPPORT requires “comprehensive screenings for seniors,” specifically including a “review of any current opioid prescriptions.”¹⁶⁶ This review requires four key components: (1) a review of risk factors for OUD, (2) an evaluation of the patient’s pain levels and treatment plan, (3) consulting information on non-opioid treatment options, and (4) a referral to a specialist, if needed.¹⁶⁷ This review is to be conducted at a beneficiary’s initial preventative physical exam upon enrolling in Medicare, and screenings for potential substance abuse disorders, as well as referral to specialists for treatment when necessary, are required at the beneficiary’s annual wellness visits.¹⁶⁸

Medicare is also required by SUPPORT to provide coverage for “certain services furnished by opioid treatment programs.”¹⁶⁹ Considering Medicare has historically not provided coverage for medications provided to beneficiaries in outpatient treatment, this provision could initiate significant change in the services available to Medicare beneficiaries.¹⁷⁰ SUPPORT specifically requires that Medicare cover opioid use disorder treatment services including treatment medications, the dispensing and administration of these medications, substance use counseling, individual and group counseling, toxicology tests, and “other items and services the Secretary determines are appropriate (but in no event to include meals or transportation).”¹⁷¹ For Medicare to recognize the treatment program as an “opioid treatment program,” the entity must be enrolled under section 1866(j) (meaning the provider has completed the application and enrollment process to receive Medicare

163. *Id.*

164. *Id.* tit. 2, § 2001.

165. TELEHEALTH SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES 4 (2019), available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctst.pdf>.

166. SUPPORT Act, *supra* note 162, tit. 2, § 2002.

167. *Id.*

168. *Id.*

169. *Id.* tit. 2, § 2005.

170. See *Medication-Assisted Treatment (MAT)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment> (last visited Nov. 4, 2019) [hereinafter *MAT*].

171. SUPPORT Act, *supra* note 162, tit. 2, § 2005.

billing privileges),¹⁷² certified by the Substance Abuse and Mental Health Services Administration (“SAMHSA”), and meet “such additional conditions as the Secretary may find necessary” to ensure the health and safety of beneficiaries, as well as the effectiveness of such programs.¹⁷³

The remaining provisions set forth in SUPPORT requiring Medicare action are primarily focused on the prescribing of opioids. First, SUPPORT requires prescriptions covered by Part D for schedule II, III, IV, or V controlled substances be prescribed electronically, subject to several exceptions.¹⁷⁴ Medicare prescription drug sponsors must also establish drug management programs for at-risk beneficiaries.¹⁷⁵ The sixth provision regarding Medicare in SUPPORT sets for the requirement of “encouraging appropriate prescribing under Medicare for victims of overdose.”¹⁷⁶ A beneficiary identified as having a history of opioid-related overdose must be included as a “potentially at-risk beneficiary,” and the prescription drug program (“PDP”) sponsor of the plan the beneficiary is enrolled in will be notified.¹⁷⁷

SUPPORT further alters the process to follow when a PDP sponsor denies or limits a beneficiary’s access to prescription drugs.¹⁷⁸ A PDP sponsor, in accordance with its drug management program, may limit or deny an at-risk beneficiary’s access to “coverage for frequently abused drugs under such plan to frequently abused drugs that are prescribed for such beneficiary by one or more prescribers selected under

172. See *Provider Enrollment Regulation*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentRegulation.html> (last visited Nov. 4, 2019) (“[W]e required that all providers and suppliers (other than physicians or non-practitioners who have elected to “opt-out” of the Medicare program) complete an enrollment application and submit specific information to CMS in order to obtain Medicare billing privileges.”).

173. *Id.*

174. SUPPORT Act, *supra* note 162, tit. 2, § 2003 (“[A] prescription for a covered part D drug under a prescription drug plan (or under an MA-PD plan) for a schedule II, III, IV, or V controlled substance shall be transmitted by a health care practitioner electronically in accordance with an electronic prescription drug program that meets the requirements of paragraph (2).”).

175. *Id.* tit. 2, § 2004.

176. *Id.* tit. 2, § 2006.

177. *Id.* (“[A] part D eligible individual who is not an exempted individual described in clause (ii) and who is identified under this clause as a part D eligible individual with a history of opioid-related overdose (as defined by the Secretary) shall be included as a potentially at-risk beneficiary for prescription drug abuse under the drug management program under this paragraph.”).

178. *Id.* tit. 2, § 2007.

subparagraph (D), and dispensed for such beneficiary by one or more pharmacies selected under such subparagraph.”¹⁷⁹ Upon the denial of access to a prescription by the PDP sponsor, SUPPORT now requires automatic, rather than optional, notice be forwarded to an external, independent entity contracted with the Secretary for review of the case.¹⁸⁰

Payment to Medicare Part D pharmacies may now also be suspended by the PDP sponsors.¹⁸¹ Previously, it was the Secretary, not the PDP sponsors, with the ability to suspend payments to Medicare providers and supplies in the event of a pending investigation of “credible fraud allegations.”¹⁸² SUPPORT has expanded this power to PDP sponsors.¹⁸³ Upon suspending a pharmacy, the PDP sponsor must notify the Secretary.¹⁸⁴

These provisions in SUPPORT may shine some hope on Medicare’s involvement in the crisis, as the Act appears to balance supply-side preventative measures, such as sponsor suspension and electronic prescribing,¹⁸⁵ with other efforts that focus on identifying at-risk beneficiaries and treating underlying substance abuse disorders.¹⁸⁶ SUPPORT includes additional provisions, discussed in Part IV, that may also be wins for Medicare and its beneficiaries, as these provisions address alternative pain treatment options and expand on OUD treatment.¹⁸⁷

IV. Recommendation

Supply-side preventative measures will fall short of solving the opioid epidemic. Tactics such as PDMPs or CMS’s overutilization monitoring system may serve a valid purpose in attempting to prevent new cases of opioid use disorders by limiting the number of opioid prescriptions being prescribed to individuals who have not yet taken opioids; this step alone will not accomplish what is so desperately needed in countering this crisis, and overreliance on such tactics will hinder real,

179. *Id.*

180. *Id.*

181. *Id.* tit. 2, § 2008.

182. *See The SUPPORT for Patients and Communities Act (P.L.115-271): Medicare Provisions*, EVERYCRSREPORT.COM (Jan. 2, 2019), https://www.everycrsreport.com/reports/R45449.html#_Toc534283040.

183. *See id.*

184. SUPPORT Act, *supra* note 162, tit. 2, § 2008.

185. *See id.* tit. 2, §§ 2003, 2008.

186. *See id.* tit. 2, §§ 2002, 2005.

187. *See infra*, Part IV.

measurable, lasting improvements in the epidemic. It is for this reason CMS should tread carefully in executing the plans set forth in the Roadmap and give proper attention and resources toward OUD and alternative pain treatment methods.

A. Alternative Pain Treatment Methods

Alternative pain treatment methods must be a top priority for the Medicare population, a population known to suffer from chronic pain.¹⁸⁸ Undoubtedly, situations exist in which the proper and necessary pain treatment method will be an opioid prescription, and it is important that Medicare sponsors are following the guidelines set forth by the CDC when relying on opioids to treat chronic pain.¹⁸⁹ Yet, if unnecessary opioid prescribing is truly a catalyst in the opioid epidemic, and plenty of evidence suggests it is contributing to the crisis, it is essential that effective alternative pain treatment methods are widely available for and utilized by Medicare beneficiaries in need of relief for very legitimate pain issues.

1. MEDICAL CANNABIS LAWS

This inevitably brings us to the medical marijuana conversation. Despite a stringent federal policy based on banning marijuana use, states are taking small steps toward forms of marijuana legalization.¹⁹⁰ While an in-depth evaluation of marijuana legalization is beyond the scope of this Note, recently passed Illinois legislation is worth briefly discussing in the context of alternative pain treatment methods. In August 2018, then-Illinois-Governor Bruce Rauner signed into law the Alternative to Opioids Act of 2018.¹⁹¹ This law allows patients to opt out of receiving an opioid prescription and instead fill a medical marijuana prescription.¹⁹² Eligibility for this program requires that patients be di-

188. See Carter, *supra* note 43, at 2.

189. See DEBRAH DOWWELL ET AL., CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016 (2016), <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>.

190. See generally Andre Bourque, *The U.S. Marijuana Movement Proves Unwavering As Voters Go Green In The 2018 Midterms*, FORBES (Nov. 8, 2018, 12:38 PM), <https://www.forbes.com/sites/andrebourque/2018/11/08/the-u-s-marijuana-movement-proves-unwavering-as-voters-go-green-in-the-2018-midterms/#328897013eaa> (discussing states' marijuana legislation initiatives on the 2018 midterm ballots).

191. S.B. 336, 99th Gen. Assemb., Reg. Sess. (Il. 2008).

192. *Id.*

agnosed with a condition for which an opioid would regularly be prescribed and that a physician complete a form on behalf of the patient to certify that the patient is in fact suffering from such a condition.¹⁹³

A principal component in the drafting of this legislation, as well as Governor Rauner's signing of the bill, was the concern that without alternative pain treatment methods, "reducing the supply of prescription opioids too abruptly may drive more people to switch to using illicit drugs."¹⁹⁴ Findings discussed within the Senate bill briefly address the tension between state and federal law, noting that approximately ninety-nine out of every 100 cannabis arrests in the United States are made under state, rather than federal, law; therefore, the change in state law will have the effect of "protecting from arrest the vast majority of seriously ill patients who have a medical need to use cannabis."¹⁹⁵ It remains to be seen what impact this piece of Illinois legislation will have in countering the opioid epidemic; however, this type of legislation demonstrates the perceived potential of using medical marijuana to limit opioid prescriptions without neglecting to treat patients' conditions.

Specifically focusing on the Medicare population, state medical marijuana laws may have a positive impact on curbing the number of opioids prescribed to Medicare Part D beneficiaries.¹⁹⁶ A study conducted by Ashley C. Bradford of the Department of Public Administration and Policy examined the association between prescribing patterns in Medicare Part D and the implementation of state medical marijuana legislation.¹⁹⁷ Bradford's five-year study reviewed the total number of daily doses for opioids prescribed in Medicare Part D in each state, examined state medical marijuana laws, and analyzed whether an association existed between states' total number of daily doses for opioids and medical marijuana laws.¹⁹⁸ Bradford found that the daily doses of opioids prescribed in a state decreased after the state implemented medical marijuana laws.¹⁹⁹ While not the purpose nor focal point of the study, Bradford additionally discussed the evidence present in existing

193. *Id.*

194. *Id.*

195. *Id.*

196. See e.g., Ashley C. Bradford et al., *Association Between US State Medical Cannabis Laws and Opioid Prescribing in the Medicare Part D Population*, 178 JAMA INTERNAL MED. 667, 671-72 (2018).

197. *Id.* at 667.

198. *Id.*

199. *Id.* at 670.

literature that medical cannabis laws have been associated with reductions in opioid-related mortality, shedding additional light on the potential role of medical marijuana in combatting the opioid epidemic.²⁰⁰

CMS, as a federal agency, is bound by federal law and cannot currently cover prescriptions for medical marijuana.²⁰¹ Also, CMS does not have the ability of a state to enact such legislation. Regardless, its support and potential future coverage for medical marijuana prescriptions may be critical to its beneficiaries receiving needed pain treatment via a method that does not put them at risk of developing OUDs. The most recently enacted federal law focusing on the opioid epidemic, SUPPORT, does not contain provisions regarding the use of medical marijuana.²⁰² While SUPPORT does incentivize hospitals and emergency departments to develop alternative pain management methods, such methods must be approved by the Food and Drug Administration (“FDA”).²⁰³ The FDA has not approved the use of marijuana as a safe and effective drug, though it has approved a drug containing cannabidiol for the specific treatment of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients who are at least two years of age.²⁰⁴ The FDA asserts its support for the scientific research into the medical use of marijuana, so while the agency has not yet provided its stamp of approval on medical marijuana, FDA approval of the use of medical marijuana in the future is not entirely out of the question.²⁰⁵

2. RESEARCHING OTHER VIABLE ALTERNATIVE PAIN MANAGEMENT OPTIONS

Medical marijuana is only one possible alternative pain management option. An additional provision of SUPPORT calls for the review of payment and coverage policies for non-opioid based medical devices, approved by the FDA, used for the treatment and management of acute and chronic pain.²⁰⁶ SUPPORT requires that the Secretary of

200. *Id.* at 671.

201. *See Medical Marijuana and Medicare Coverage*, MEDICARE FAQ, <https://www.medicarefaq.com/faqs/medical-marijuana-and-medicare-coverage/?eiid=1991721394.1547674714> (last visited Nov. 4, 2019).

202. *See* SUPPORT Act, *supra* note 162.

203. *Id.* tit. 7, § 7091.

204. *FDA and Medical Marijuana*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/newsevents/publichealthfocus/ucm421163.htm> (last visited Nov. 4, 2019).

205. *Id.*

206. SUPPORT Act, *supra* note 162, tit. 6, § 6032.

Health and Human Services carry out a demonstration program, in which hospitals and freestanding emergency departments are awarded grants to “develop, implement, enhance, or study alternatives to opioids for pain management in such settings.”²⁰⁷ Recipients of these grants must provide a report to the Secretary that details the opioid alternative pain management programs, data on the strategies used, and data on the patients who were ultimately prescribed opioids after first being treated with the alternative pain management method.²⁰⁸

While SUPPORT does not detail what alternative pain treatment methods might be utilized, the grants incentivizing the use of alternative pain treatment methods are a proactive approach to finding methods that are effective, and those that are not, as well as identifying the types of patients and conditions for which alternative pain treatment methods are most and least appropriate. The information obtained through these demonstration programs may prove instrumental in improving the pain treatment practices used to alleviate older patients’ pain symptoms.

B. Treating the Underlying Substance Abuse Disorders

While pain is one factor in the opioid epidemic, underlying substance use disorders (“SUD”) continue to be a key driver of the crisis.²⁰⁹ Medication-assisted treatment (“MAT”) is one route utilized for the treatment of substance abuse disorders, including OUDs. MAT combines the use of FDA-approved medications, such as buprenorphine, methadone, or extended release naltrexone, and counseling therapies to treat SUDs in a “whole-patient” approach.²¹⁰ The medications relieve substance withdrawal symptoms and “psychological cravings that cause chemical imbalances in the body.”²¹¹

Thus far, MAT appears to be well-received by the professionals in drug treatment.²¹² A 2013 study conducted by Robert P. Schwartz, the

207. *Id.* tit. 7, § 7091.

208. *Id.*

209. See Nora D. Volkrow et al., *Medication-Assisted Therapies—Tackling the Opioid-Overdose Epidemic*, 370 *NEW ENG. J. MED.* 2063 (2014).

210. See *MAT*, *supra* note 170.

211. *Medication and Treatment Counseling*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat> (last visited Nov. 4, 2019).

212. See *Effective Treatments for Opioid Addiction*, NAT. INST. FOR DRUG ABUSE, <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction> (last visited Nov. 4, 2019).

Medical Director of Friends Research Institute, examined the effects expanded methadone and buprenorphine treatments had on the heroin overdose deaths in Baltimore.²¹³ Baltimore, the city with the largest increase in heroin overdose deaths in the 1990s, experienced a sharp decrease in heroin overdoses after the state of Maryland and Baltimore City expanded methadone and buprenorphine treatment.²¹⁴

Interestingly, the improvement in overdose statistics began to pick up after 2003, the year buprenorphine access was expanded with the already available methadone treatments.²¹⁵ Between 2003 and 2009, average annual heroin overdose deaths in Baltimore decreased by thirty-seven percent after buprenorphine became available.²¹⁶ Schwartz's study sheds valuable light on the effectiveness of MAT treatment for individuals struggling with opioid addiction, especially MAT's ability to decrease opioid overdose deaths, and draws attention to potential differences in efficacy of the various MAT drugs used.²¹⁷

Fortunately, CMS specifically highlights the use of MAT in its "treatment" plan set forth in the 2018 Roadmap.²¹⁸ However, simply stating an intent to expand MAT access without taking the necessary steps to ensure MAT is accessible to beneficiaries and provided in effective manners will prove to be an empty promise. An examination of state Medicaid programs' approaches to MAT may be a logical starting point for CMS in furthering its understanding of how to generate favorable results using MAT.²¹⁹ The effectiveness of MAT is "dependent upon the ability to provide treatment that simultaneously addresses the totality of a patient's comorbid substance use disorders and mental health problems."²²⁰ In evaluating the effectiveness of state Medicaid programs' MAT methods, lack of provider ability, provider's unwill-

213. See Robert P. Schwartz et al., *Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009*, 103 AM. J. PUB. HEALTH 917 (2013) [hereinafter Schwartz et al.].

214. *Id.* at 920.

215. *Id.* at 919.

216. *Id.*

217. *Id.* at 921.

218. CMS ROADMAP, *supra* note 12, at 3.

219. See generally Page M. Smith, Note, *Implementing Medicaid Health Homes to Provide Medication Assisted Treatment to Opioid Dependent Medicaid Beneficiaries*, 106 KY. L.J. 111, 114 (2017) (discussing the efficacy of state Medicaid MAT programs).

220. *Id.* at 126.

ingness to prescribe MAT, lack of behavioral health services, and reimbursement concerns are issues that inhibit the potential effectiveness of MAT.²²¹

Coverage for, as well as access to, MAT is imperative. Like the intentions discussed in the 2018 Roadmap, CMS emphasized the importance of MAT in its 2017 Opioid Misuse Strategy.²²² In doing so, CMS acknowledged the struggles surrounding coverage of and access to MAT.²²³ As stated within the Opioid Misuse Strategy, Medicare Part D formularies are required to include covered Part D drugs used for MAT, and CMS mandates Part C coverage for the behavior health treatment element of MAT.²²⁴ Part D, however, is a reimbursement program for *pharmacies*, meaning Part D formerly did not cover the costs of MAT drugs when given at an opioid treatment program.²²⁵ As a result, Medicare did not cover the costs of MAT when provided on an outpatient basis.²²⁶

Fortunately, SUPPORT expanded Medicare coverage to include MAT services delivered at Opioid Treatment Programs (“OTP”).²²⁷ While CMS provides details of how it intends to expand access to and coverage for MAT in Medicaid, which primarily involves working closely with states to push for the implementation of policies within state Medicaid programs that expand the coverage of MAT, the Roadmap gives little attention to how CMS will overcome the coverage and access barriers impacting Medicare beneficiaries.²²⁸ Luckily, some of the coverage concerns have been alleviated with the passage of SUPPORT, as Medicare beneficiaries will have the ability to seek treatment from OTPs.²²⁹ Sufficient access to OTPs will still, in part, depend

221. *Id.* at 131.

222. *See* OPIOID MISUSE STRATEGY 2016, *supra* note 77, at 16.

223. *See id.*

224. *Id.* at 17.

225. *Id.*

226. *See Insurance and Payments*, Substance Abuse & Mental Health Services Admin., <https://www.samhsa.gov/medication-assisted-treatment/treatment/insurance-payments> (last visited Feb. 14, 2019).

227. SUPPORT Act, *supra* note 162, tit. 2, § 2005.

228. *See* OPIOID MISUSE STRATEGY 2016, *supra* note 77, at 18–19 (“CMS will continue to work with states to implement policies in their Medicaid programs that ensure broad coverage of and access to FDA-approved medications to treat opioid use disorder as well as the other components of evidence-based MAT, including counseling and care management.”).

229. SUPPORT Act, *supra* note 162, tit. 2, § 2005.

on the enrollment of an adequate number of OTPs in Medicare that beneficiaries can access.²³⁰

In addition to expanding MAT coverage, pursuant to the amendments made to Medicare provisions in the passage of SUPPORT,²³¹ CMS should also give attention to studies that have been conducted examining the success of MAT, such as Schwartz's 2013 study discussed above, to ensure MAT treatments provided by Medicare-certified programs and facilities to beneficiaries are designed with the best possible chances of effectively treating beneficiaries' OUDs.²³² CMS, to carry out the full potential MAT may offer in addressing the opioid epidemic, must focus on these identified problem areas and commit to providing comprehensive coverage for MAT services.

V. Conclusion

The opioid epidemic is a complex problem that continues to impact every age group. Despite being glossed over in much of the news coverage of the epidemic, the United States' senior citizens are far from removed from the crisis.²³³ Not only are senior citizens vulnerable to underlying factors leading to substance abuse disorders, they are especially susceptible to chronic pain. Senior citizens continue to suffer from the opioid epidemic, and it is overwhelmingly clear that Medicare, or CMS, with over fifty-million beneficiaries age sixty-five and over, will play a crucial role in correcting the underlying issues contributing to the larger opioid epidemic.²³⁴

It is also clear that CMS recognizes this duty, and its Roadmap for combatting the epidemic has the potential to make a measurable, lasting impact; however, the success of CMS's plan will largely turn on whether CMS resists the urge to overemphasize supply-side prevention tactics, giving adequate attention and resources to methods that will address both the pain needs of the Medicare population and underlying opioid use disorders, such as alternative pain management methods and MAT. Despite states' implementation of supply-side methods

230. See *id.* (requiring opioid treatment programs be enrolled under 1866(j) for Medicare coverage to be available to beneficiaries).

231. *Id.*

232. See Schwartz et al., *supra* note 213 (examining the effectiveness of Baltimore's MAT expansion).

233. See Friello, *supra* note 6, at 10; Schilling, *supra* note 6, at 1; Guydish, *supra* note 6.

234. CMS FAST FACTS, *supra* note 74, at 1.

to reduce access to opioids, such as PDMPs, the opioid epidemic's hold on the nation is not letting up. Quite to the contrary, the crisis only continues to worsen.²³⁵ CMS must not overlook this fact as it works to address the epidemic crippling the United States', including CMS's very own Medicare beneficiaries.

235. See Debra Goldschmidt, 'Opioid Overdose Epidemic Continues to Worsen and Evolve,' *CDC Says*, CNN (Dec. 22, 2018, 3:15 AM), <https://www.cnn.com/2018/12/22/health/illegal-fentanyl-driving-opioid-epidemic-cdc-bn/index.html>.