THE PEW CHARITABLE TRUSTS

2005 Market Street, Suite 1700 215.575.9050 Phone
Philadelphia, PA 19103-7077 215.575.4939 Fax

901 E Street NW, 10th Floor 202.552.2000 Phone
Washington, DC 20004 202.552.2299 Fax
www.pewtrusts.org

February 16, 2018

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Senator
221 Dirksen Senate Office Bldg.
Washington, D.C., 20510

Chairman Hatch and Ranking Member Wyden:

Thank you for the invitation to provide feedback to the Senate Finance Committee on ways to address the opioid crisis, which currently claims 115 lives per day.[i]

The Pew Charitable Trusts, a non-profit, non-partisan research and policy organization, through its Substance Use Prevention and Treatment Initiative, is working to develop and support state and federal policies that: 1) reduce the inappropriate use of prescription drugs; and 2) expand access to effective treatment for substance use disorders. As part of this effort, Pew has provided recommendations to both Indiana and Wisconsin[ii] outlining ways to improve access to high-quality treatment.

Actions to address this epidemic are urgently needed, and should encompass efforts to reduce inappropriate use of opioids, prevent harm from the drugs and improve access to, and quality of, treatment for substance use disorder. Our comments focus largely on treatment.

Opioid use disorder (OUD) is a chronic brain disease caused by the recurrent use of opioids. Unfortunately, many people with OUD are not able to access any treatment at all. Only 10% of people with substance use disorders (which include OUD) receive any treatment for their disorder.[iii]

A conclusive body of research has demonstrated that medication-assisted treatment (MAT) is the most effective way to treat OUD. MAT combines one of the medications approved by the Food and Drug Administration (FDA) for the treatment of OUD—methadone, buprenorphine and naltrexone—with non-drug therapies, such as counseling. People who receive MAT are less likely to die of overdose, use illicit opioids and contract infectious diseases such as HIV and hepatitis C.[iv]

Unfortunately, it is difficult for many people to access MAT. Fewer than one-quarter of publicly-funded treatment programs offer any of the FDA-approved medications to treat OUD, and less than half of private-sector treatment programs use these medications.[v] Access can be particularly difficult in rural areas; nearly half of rural counties do not have any provider who can prescribe buprenorphine.[vi]

We suggest looking at the following areas as you explore ways to improve access to high-quality treatment:

- *Medicare and Medicaid coverage of FDA-approved medications.* Unfortunately, state Medicaid programs do not always facilitate access to all three FDA-approved medications; for example, many states do not cover methadone for the treatment of OUD.[vii] Additionally, states may require prior authorization or implement other processes that restrict access to these medications. Medicaid programs should streamline access to these three medications to

the greatest degree possible, for people in both fee-for-service (FFS) and Medicaid managed care organizations (MCOs). Furthermore, Medicare Part B does not cover methadone for the treatment of OUD.

- *Medicare and Medicaid coverage of all ASAM levels of care.* The American Society for Addiction Medicine (ASAM) has established principles[viii] outlining levels of care that range from early intervention and outpatient treatment to medically- managed intensive inpatient services. The right level for any individual in treatment depends on the severity of his or her disease, co-occurring disorders, the stability of his or her social situation, and other factors. However, not all state Medicaid programs cover all levels of care.[ix] Given that the treatment for OUD should be individualized, Medicaid FFS and MCOs should ensure that beneficiaries are able to access all levels of care, when appropriate, but should also take steps to limit use of expensive interventions (such as extended in-patient care) when less-costly and equally effective treatments are clinically appropriate.

- *Innovative treatment models.* Many states and local jurisdictions have implemented innovative treatment models that have shown significant promise in saving lives and improving other outcomes by connecting patients to MAT. For example, Vermont has implemented a 'hub-and-spoke'[x] system where patients receive acute withdrawal management services at specific hubs in the state, but are generally managed on a long-term basis by community-based providers. This system has reduced wait lists at treatment facilities; Vermont now has the highest per capita capacity to treat OUD patients of any state in the country.[xi] Similarly, Rhode Island has designated Centers of Excellence[xii] for the treatment of complex patients and those initiating care. Governor Scott Walker recently issued an executive order[xiii] directing state officials to explore the implementation of models such as these in Wisconsin.

  States are implementing other emerging models that focus on initiating and maintaining patients in treatment. For example, Project ECHO, which was pioneered by the University of New Mexico, uses technology to connect providers, particularly those in rural and underserved areas, with specialists located elsewhere. This program has increased the number of physicians eligible to prescribe buprenorphine.[xiv] The United States Surgeon General has identified as promising a model that utilizes emergency department personnel to initiate or refer a patient to OUD treatment following an overdose incident—a critical point when an individual may be more receptive to treatment.[xv] Rhode Island's Anchor ED program, which has successfully connected overdose victims with peer recovery specialists who work to engage these individuals in treatment, is an example of this model.[xvi] The successful implementation of these and other models relies on a reimbursement structure that reflects the complexity of OUD treatment and encourages providers to engage in the treatment system.

  These—and other models—have benefitted from federal support at many levels. The Center for Medicare & Medicaid Services' (CMS) Innovation Accelerator Program has provided states with access to technical expertise and needed resources to implement a continuum of care. Additionally, the State Targeted Response to the Opioid Crisis grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) have been essential to states in efforts to build out access to high-quality services. These federal funds

have advanced state adoption of promising treatment models and will help connect more people to evidence-based care.

Finally, at the direction of Congress, CMS recently issued a proposed rule[xvii] intended to reduce the inappropriate prescribing of opioids. The rule addresses how Medicare Part D plans can implement patient review and restriction (PRR) programs, which are used to identify at-risk beneficiaries and assign them to designated pharmacies, prescribers or both for their controlled substance needs. However, as we outlined in a recent letter to CMS[xviii], this rule includes a number of provisions that will reduce its effectiveness. We encourage you to work with CMS to ensure the program is improved.

Thank you for the opportunity to provide the committee with feedback. We look forward to working with you to reduce the human toll related to the opioid crisis. Please do not hesitate to contact me at creilly@pewtrusts.org or 202-540-6916 with any questions.

Sincerely,

Cynthia Reilly, MS, BS Pharm
Project Director, Substance Use Prevention and Treatment Initiative

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[i] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention. Drug Overdose Deaths in the United States Continue to Increase in 2016. August 30, 2017. https://www.cdc.gov/drugoverdose/epidemic/index.html

[ii] 2017 Combatting Opioid Abuse, A Report to Governor Scott Walker. 2017. https://hope.wi.gov/Documents/Jan18%20Opioid%20Report%20JH%202.pdf

[iii] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf

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[ix] Ibid.
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