Written Testimony of

Paul Christine, MD, PhD
Assistant Professor of Medicine
University of Colorado School of Medicine and Denver Health

Before the U.S. Senate Finance Health Care Subcommittee
April 9, 2024

Hearing Title: Closing Gaps in the Care Continuum: Opportunities to Improve Substance Use Disorder Care in the Federal Health Programs

Chairman Cardin, Ranking Member Daines, and distinguished members of the committee thank you for the opportunity to speak with you today. My name is Paul Christine, and I am an Assistant Professor of Medicine at the University of Colorado School of Medicine and Denver Health, Denver's safety-net health system. It is an honor to provide testimony regarding opportunities for the federal health programs to improve the treatment and prevention of substance use disorders.

I have the privilege of practicing as a primary care physician and addiction medicine specialist at Denver Health's Westside Family Health Center, a community health center in Denver, Colorado. In that role, I work as part of a multidisciplinary team to provide comprehensive treatment for individuals with substance use disorders. This includes providing all three medications for opioid use disorder – buprenorphine, methadone, and naltrexone – which is rare given the regulatory requirements for methadone treatment. I am also a health services and policy researcher who studies the effects of health and social policies on the availability and quality of treatment for patients with substance use disorders. My recent research has focused on policy issues that influence access to evidence-based treatment for opioid use disorder in Medicaid, including prior authorization policies and insurance instability. In my clinical practice, I witness daily the very things that I study – how insurance policies affect the care of patients with substance use disorders.

Drawing from my dual perspective as a physician and researcher, I will focus my testimony on three main topics:

1. Insurance barriers to effective addiction care
2. Acknowledging the complexity of addiction care and paying for what works
3. Testing innovative approaches to improve addiction care

Insurance Barriers to Effective Addiction Care
As a practicing primary care provider, I am accustomed to navigating various insurance barriers to provide my patients with needed treatment. However, when it comes to

addiction care, insurance barriers that cause delays in initiating or maintaining effective care can be particularly onerous for clinicians and harmful to patients.

I would like to offer you a window into what it's like for my patients to seek outpatient treatment for opioid use disorder, also known as opioid addiction. These patients have decided to pursue treatment despite historically being stigmatized by the medical system. They are often in opioid withdrawal, characterized by severe physical and psychological distress with symptoms including profuse sweating, vomiting, diarrhea, and muscle aches. Treatment with medications for opioid use disorder, such as buprenorphine and methadone, medications that are proven to reduce morbidity and mortality related to opioid use by 50 percent, can quickly relieve these symptoms and rapidly stabilize patients.[1] However, for some patients, immediate treatment with these life-saving medications can be delayed due to needing prior authorization approval.

There are only three Federal Drug Administration (FDA)-approved medications to treat opioid use disorder: naltrexone, an opioid blocker; buprenorphine, a partial-opioid agonist; and methadone, a full opioid agonist. With only three options for treatment, there are no other "first line" treatments that patients should be encouraged to try prior to initiating these highly efficacious medications. Furthermore, these medications are relatively inexpensive, and they also reduce both mortality and costly comorbidities like chronic hepatitis C infection and HIV.[2,3] Medicare and Medicaid now cover at least one formulation of each of these three medications for opioid use disorder. However, research shows that many insurers, including many Medicaid-managed care organizations, continue to require prior authorizations for these life-saving medications.[4] There is no clinical or economic justification for requiring prior authorization for life-saving and cost-saving medications for opioid use disorder. Prior authorizations for medications for opioid use disorder, as well as other state Medicaid policies that place dose and time limits on buprenorphine treatment, are not rooted in evidence and place an unnecessary hurdle in the way of effective addiction care.

Following guidance issued by the FDA and the Centers for Medicare and Medicaid Services (CMS), most Medicare Part D plans removed prior authorization requirements for buprenorphine between 2017 and 2019. Research evaluating this policy change showed that more patients initiated buprenorphine treatment and that hospitalizations and emergency department visits declined.[5] Studies of Medicaid prior authorization removals, including my own, have shown more mixed results. [6,7] However, there is evidence that the imposition of Medicaid prior authorizations can interrupt treatment,[8] leading patients to stop medication and placing them at risk of overdose if they return to drug use.

When patients take the step to initiate treatment for opioid use disorder, this should be viewed as an emergency where prompt access to life-saving treatment must be provided. Prior authorizations and other non-evidence-based policies like dose and duration limits are inconsistent with the scale of the risk involved with failing to treat these patients quickly with effective medications.

Acknowledging the Complexity of Addiction Care and Paying for What Works
In my role as a physician providing integrated primary care and addiction care in a community health center, I am part of an interdisciplinary team that seeks to provide holistic, comprehensive care for patients in high-need locations with limited access to health care. This team includes a substance treatment counselor, a social worker, a registered nurse, and a peer recovery advocate (a person with lived experience of drug use who is now in recovery). When I recently had a patient present to my clinic seeking to initiate treatment for opioid and stimulant use disorders, all these team members contributed to the patient's care. I saw the patient and prescribed medication, the nurse treated the patient's chronic skin wound, the counselor offered psychotherapy to address underlying mental health issues, the social worker assisted with referrals to housing services, and the peer recovery advocate provided resources for local recovery meetings and offered to accompany the patient to help them build a community of peers in recovery from addiction.

Despite the complexity of the care that was delivered, only a fraction of the services that were provided by our care team are consistently reimbursable in the federal health programs, and often at rates that undervalue the comprehensive care being delivered.[9,10] State Medicaid programs have wide variability in their payment for non-physician services, including nurse visits, care coordination, and peer recovery support. Some states and insurers have developed novel mechanisms to reimburse wraparound services for addiction care, but many such services remain uncompensated or are only temporarily grant-funded.[10] Value-based payment models are a promising potential solution, though quality metrics for addiction care remain underdeveloped.[11] To provide the sort of comprehensive care needed to support patients on their path to recovery, we must be able to pay for the services that meet patients' needs. Such a team-based approach to care also underscores the importance of continuing to invest in the addiction workforce pathway through federal workforce programs like graduate medical education and the Health Resources and Services Administration.

Aside from the required interdisciplinary team care, there are also evidence-based treatments that remain underutilized due to little fiscal support from federal health programs. For example, contingency management is a behavioral therapy that provides positive reinforcement for desired behaviors through incentives. In the case of stimulant use disorder, where patients are addicted to cocaine or methamphetamine, contingency management has been consistently shown to reduce drug use and improve treatment retention.[12,13] Despite the demonstrated efficacy of contingency management, CMS imposes annual maximum limits for contingency management of $75, far below the demonstrated effective levels of $400-500 per patient during the course of treatment.[14,15] Given that there are no FDA-approved medications for stimulant use disorder, there is an urgent need for federal health programs to consider actively supporting contingency management programs and raising the annual limits for these programs.

Testing Innovative Approaches to Improve Addiction Care

Despite the barriers to addiction treatment highlighted above, there are reasons for hope going forward. There are multiple innovations involving the federal health programs that aim to evaluate and improve care for patients with addiction. State Medicaid Section 1115 waivers represent perhaps the fastest-growing area of innovation for addiction care delivery. While some 1115 waivers directly target reimbursement for the full spectrum of addiction care, two of the most promising applications involve 1) addressing underlying health-related social needs, and 2) connecting individuals being released from incarceration to further care.

At Denver Health, I frequently see patients start medications for their addiction, rapidly stabilize during their hospitalization, and then get discharged right back to the streets where they had been living and using drugs. Both inpatient and outpatient care providers frequently seek to connect their patients to housing resources that are often in short supply with limited funding. Section 1115 waivers that authorize Medicaid to pay for supportive housing may provide crucial stabilization to patients struggling with addiction. My home state of Colorado is currently considering a Section 1115 waiver that would allow Medicaid reimbursement for housing and nutrition, which would provide needed support to many of my patients. Rigorous evaluation of these efforts to tackle the health-related social needs inhibiting recovery from addiction will be important to informing future federal policy in this area.

Another promising innovation that could impact addiction care are Section 1115 waivers that seek to allow Medicaid to cover medical services for incarcerated individuals up to 90 days prior to their release. Currently, up to 65 percent of these individuals are estimated to have a substance use disorder[16] and are at exceedingly high risk of overdose and death in the first weeks after their release.[17,18] By allowing Medicaid programs to enroll individuals and pay for care prior to release, such programs can connect patients to community healthcare providers like me and can promote a smoother transition from incarceration to the community. Providing stable insurance for those exiting incarceration, coupled with increasing treatment for substance use disorders in jails and prisons, may decrease the risk of post-release overdose and improve retention in addiction care.[19,20]

The innovations highlighted above, as well as other models of care, demand rigorous evaluation efforts and high-quality data. The CMS Innovation Center can help spur testing these models to figure out what works. However, data around many addiction treatment modalities remain limited relative to other health conditions, with little incentive for clinics and treatment programs to collect and report the data needed to create quality metrics.[9] Data regarding methadone treatment in particular, including clinic retention and practice patterns, are notoriously limited. If CMS were to adopt a pay-to-report approach where clinics and treatment programs are incentivized or mandated to report data, it would improve the ability to identify best practices and create value-based payment models that promote high-quality care.

Policy Considerations:
Priority recommendations to improve the provision of addiction care in the federal health programs include:

1. Ensure mandatory federal coverage and removal of prior authorization requirements for all FDA-approved formulations of medications for opioid use disorder. For Medicaid, this would involve making the SUPPORT Act requirements, which sunset in 2025, permanent. Such medications are lifesaving, cost-effective, and should be available quickly when patients are seeking to initiate or continue treatment.

2. Consider reimbursement models and workforce development programs that promote the comprehensive services needed by many patients struggling with addiction. This includes providing reimbursement for care coordination and peer recovery supports, promoting evidence-based practices that work, and exploring value-based reimbursement models.

3. Continue to promote and test innovative models to improve addiction care, including efforts to address health-related social needs and transitions in care. Testing such innovations will require improved data collection and reporting, which can be incentivized by CMS.

Lastly, it is crucial for the committee to include the voices and ideas of those with lived experience of drug use in conversations about how to improve their care. My patients are the true experts in addiction care, and their knowledge about what has and has not worked for them, what barriers they encountered for treatment, and what aided them in their recovery can help us all build a better treatment system.

Thank you again for inviting me to testify on this very important topic, and I look forward to answering your questions.

References:

1. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550. doi:10.1136/bmj.j1550
2. Platt L, Minozzi S, Reed J, et al. Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta-analysis. *Addiction*. 2018;113(3):545-563. doi:10.1111/add.14012
3. MacArthur GJ, Minozzi S, Martin N, et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. *BMJ*. 2012;345(oct03 3):e5945-e5945. doi:10.1136/bmj.e5945
4. Abraham AJ, Andrews CM, Harris SJ, Westlake MM, Grogan CM. Coverage and Prior Authorization Policies for Medications for Opioid Use Disorder in Medicaid Managed Care. *JAMA Health Forum*. 2022;3(11):e224001. doi:10.1001/jamahealthforum.2022.4001
5. Mark TL, Parish WJ, Zarkin GA. Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries. *JAMA Netw Open*. 2020;3(4):e203132. doi:10.1001/jamanetworkopen.2020.3132
6. Keshwani S, Maguire M, Goodin A, Lo-Ciganic WH, Wilson DL, Hincapie-Castillo JM. Buprenorphine Use Trends Following Removal of Prior Authorization Policies for the Treatment of Opioid Use Disorder in 2 State Medicaid Programs. *JAMA Health Forum*. 2022;3(6):e221757. doi:10.1001/jamahealthforum.2022.1757
7. Christine PJ, Larochelle MR, Lin L (Allison), McBride J, Tipirneni R. Removal of Medicaid Prior Authorization Requirements and Buprenorphine Treatment for Opioid Use Disorder. *JAMA Health Forum*. 2023;4(10):e233549. doi:10.1001/jamahealthforum.2023.3549
8. Landis RK, Opper I, Saloner B, et al. Buprenorphine treatment episode duration, dosage, and concurrent prescribing of benzodiazepines and opioid analgesics: The effects of Medicaid prior authorization policies. *Drug Alcohol Depend*. 2022;241:109669. doi:10.1016/j.drugalcdep.2022.109669
9. McGinty EE, White SA, Eisenberg MD, Palmer NR, Brown CH, Saloner BK. US payment policy for medications to treat opioid use disorder: landscape and opportunities. *Health Aff Sch*. 2024;2(3):qxae024. doi:10.1093/haschl/qxae024
10. Hodgkin D, Horgan C, Bart G. Financial sustainability of payment models for office-based opioid treatment in outpatient clinics. *Addict Sci Clin Pract*. 2021;16(1):45. doi:10.1186/s13722-021-00253-7
11. Incze MA, Kelley AT, Gordon AJ. Improving Opioid Use Disorder Treatment through Quality Assessment. *J Gen Intern Med*. 2021;36(9):2820-2822. doi:10.1007/s11606-021-06614-x
12. Prendergast M, Podus D, Finney J, Greenwell L, Roll J. Contingency management for treatment of substance use disorders: a meta-analysis. *Addiction*. 2006;101(11):1546-1560. doi:10.1111/j.1360-0443.2006.01581.x
13. Brown HD, DeFulio A. Contingency management for the treatment of methamphetamine use disorder: A systematic review. *Drug Alcohol Depend*. 2020;216:108307. doi:10.1016/j.drugalcdep.2020.108307

14. Lussier JP, Heil SH, Mongeon JA, Badger GJ, Higgins ST. A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction*. 2006;101(2):192-203. doi:10.1111/j.1360-0443.2006.01311.x
15. Glass JE, Nunes EV, Bradley KA. Contingency Management: A Highly Effective Treatment For Substance Use Disorders And The Legal Barriers That Stand In Its Way. Published online March 11, 2020. doi:10.1377/forefront.20200305.965186
16. National Institute on Drug Abuse. *Criminal Justice DrugFacts*.; 2020. Accessed April 2, 2024. https://nida.nih.gov/publications/drugfacts/criminal-justice
17. Binswanger IA, Stern MF, Deyo RA, et al. Release from Prison — A High Risk of Death for Former Inmates. *N Engl J Med*. 2007;356(2):157-165. doi:10.1056/NEJMsa064115
18. Binswanger IA. Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009. *Ann Intern Med*. 2013;159(9):592. doi:10.7326/0003-4819-159-9-201311050-00005
19. Lim S, Cherian T, Katyal M, et al. Association between jail-based methadone or buprenorphine treatment for opioid use disorder and overdose mortality after release from New York City jails 2011–17. *Addiction*. 2023;118(3):459-467. doi:10.1111/add.16071
20. Bovell-Ammon BJ, Yan S, Dunn D, et al. Prison Buprenorphine Implementation and Postrelease Opioid Use Disorder Outcomes. *JAMA Netw Open*. 2024;7(3):e242732. doi:10.1001/jamanetworkopen.2024.2732