HARVARD MEDICAL SCHOOL
DEPARTMENT OF HEALTH CARE POLICY

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To the Committee:

We appreciate your committee's leadership in responding to the opioid epidemic and the opportunity to offer input to your deliberations. Based on experience as researchers and public policy advisors; we believe that there are multiple avenues through which Medicare and Medicaid can improve the nation's response to the epidemic.

The opioid epidemic is fundamentally different from prior drug epidemics in that the health care system and its regulators were centrally involved in creating it through massive overprescribing. This historic failure has an ironic practical implication: The health care financing and delivery systems have the power to significantly reduce the problem on the supply side, and of course to enhance treatment services on the demand side, where Medicaid has become the dominant public sector payer.

Our expertise positions us to address four questions on which you have requested input, noted below:

How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?

The top priority for both state and federal policy should be to expand provision of medication-assisted therapies (MAT) and other evidence-based treatments to serve the full range of populations at highest risk. Expanding the scope and quality of outpatient MAT is probably the most cost-effective available single measure.

The President's Commission Combating Drug Addiction and the Opioid Crisis notes that Medicare creates important, readily-addressed gaps in the provision of MAT. Medicare Part D reimburses methadone for pain (an especially deadly prescription opioid) but not for treatment of opioid use disorder where it is an especially effective intervention. Medicare Part B reimburses methadone maintenance treatment provided within an inpatient setting, but this is a very small part of how this treatment is typically provided. Roughly 90% of treatment for opioid use disorder is supplied on an outpatient basis. We support the suggestion by Congressman Richard Neal and others to have Part D cover methadone maintenance for opioid use disorder.

Medicaid serves a central role in promoting access to care for opioid use disorder; more than 50% of people with an opioid use disorder have low incomes (under 250% of the federal poverty line). Ours and others' analyses of state Medicaid policies suggest that the range and quality of addiction treatment coverage have improved in recent years. Constraints on care such as requirements for prior authorization, annual and lifetime limits have declined following the passage of MHPAEA and the ACA.

Despite heartening progress, many states still do not cover American Society for Addiction Medicine's (ASAM) recommended continuum of care. [1] To note the most egregious example, ten state Medicaid programs apparently do not cover methadone maintenance therapy. Medicaid coverage restrictions constrain access to MAT and other evidence-based treatment. Saloner and colleagues (2016) find that 45 percent of Medicaid-enrolled opioid treatment clients were receiving opioid agonist treatment (OAT) in states that cover methadone maintenance, compared with 30 percent in states with block grant coverage only, and only 17 percent in states that had no coverage.[2] Such access differences appeared widest in non-intensive outpatient settings where ready access to MAT is especially beneficial. The President's budget request wisely proposes that Medicaid be required to cover all forms of MAT. We believe this is an especially effective (and cost-effective) proposal.

People receiving MAT typically require additional services that address co-occurring mental health, vocational, and family concerns. Medicaid reimbursement rates for many such services (e.g., psychotherapy) are low relative to private and other public insurance programs, which serves to limit provider participation within a group of professionals who are already in short supply. These realities reduce treatment access, even when someone living with a opioid use disorder is enrolled in Medicaid, and lives in a state that nominally provides generous benefits. Medicare's reimbursement rates are typically higher than Medicaid's, but are still generally less than private insurers. In light of the opioid epidemic, Medicaid and Medicare programs should expand both the range of psychosocial service for patients with substance use-related disorders as well as the rate at which such care is reimbursed.

Against the spirit of MHPAEA, many states continue to impose policies such as higher required copayments or more extensive requirements for prior authorization for services that limit access to care for substance use disorder treatment. Such barriers are particularly likely to reduce the number of people in need who enter treatment in light of the continuing stigma associated with addiction, and in light of the ambivalence harbored by many patients towards treatment itself.

Thirty percent of states continue to prohibit coverage for any residential treatment. Although we believe wholesale abandonment of the IMD exclusion could increase costs of care without necessarily improving outcomes, Medicaid waivers of the IMD exclusion that provide some support for residential treatment within a well-defined continuum of care would improve care to high-priority populations. Many states continue to deny coverage for intensive outpatient and peer recovery support. These services are important to support individuals in achieving and maintaining recovery. Finally, coverage for methadone maintenance continues to lag behind coverage for other medications for treatment of opioid use disorder.

Federal policy could also ensure better coordination between the criminal justice system and addiction treatment. For example SAMHSA-supported drug courts and other problem-solving courts must provide MAT and should not penalize patients for non-compliance when they test positive for medically-approved treatments.

Medicaid managed care provides a particularly important arena to more-carefully monitor reimbursement practices and provide financial incentives to properly align plans' utilization controls and quality control mechanisms with best-practice addiction treatment. Moreover, these organizations are subject to MHPAEA provision to offer comparable treatment for substance use disorders and medical-surgical conditions.

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[2] Brendan Saloner, Kenneth B. Stoller, and Colleen L. Barry. Medicaid Coverage for Methadone Maintenance and Use of Opioid Agonist Therapy in Specialty Addiction Treatment. *Psychiatric Services* 2016 67:6, 676-679.

Finally, as fentanyl and related substances have been more prevalent and implicated in acceleration of mortality from opioid overdoses—standard purchasing of naloxone the opioid overdose reversal drug is not adequate to reverse many overdoses involving fentanyl. The naloxone doses typically available in "take home" form or in typical injectable kits are 1/5 of the dose necessary to reverse most fentanyl overdoses. That reduces the effectiveness of naloxone as a prevention method and raises the costs of equipping first responders. Our coding, procurement and pricing in Medicaid should be altered so that the right doses of naloxone are in the right hands at the right time.

What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs (PDMP)?

PDMPs show promise in slowing the flow into opioid disorders, identifying problematic prescribers and deterring or detecting problematic patterns of use, including provider-shopping and other high-risk behaviors such as combined opioid/ benzodiazepines use.

The quality and design choices of states' PDMP programs influence the clinical impact of these interventions. Some states require providers to check PDMPs whenever they initiate or refill a prescription for a controlled substance. Others increase uptake by improving the provider user experience, by providing specific incentives for PDMP use, such as reimbursing providers for the time accessing PDMPs or by providing protection from liability when a PDMP has been used. The federal government is ideally positioned to support sharing of data across state lines, which makes it more difficult for patients or dealers to doctor shop undetected.

Recent analyses of Medicare Part D data suggest that "must access" PDMPs have much greater impact on opioid misuse than do PDMPs which are optional for medical providers, or which providers only utilize to address specific suspicions.[3] Requiring opioid prescribers to actually use PDMPs, and providing proper training and improved ease-of-use will increase the effectiveness of these resources. One potential avenue for public-private partnership in this area is to provide grants to companies that design electronic healthcare records to support their efforts to seamlessly integrate state PDMP data into the systems which providers already understand and access regularly to inform their care of patients.

What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

Medicaid waiver programs such as Arizona's seek closer coordination between Medicaid and correctional health.[4] These command especially close attention, given the particular vulnerabilities and social impact of this population. People leaving correction facilities have roughly 3 times the mortality rate of the general population much of it due to overdoses. Individuals with drug use disorders also face high risk for relapse and other adverse outcomes when they exit jails, prisons,

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[3] Buchmueller, Thomas C., and Colleen Carey. 2018. "The Effect of Prescription Drug Monitoring Programs on Opioid Utilization in Medicare." American Economic Journal: Economic Policy, 10(1): 77-112.

[4] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/az/az-hccc-fs.pdf

and other secure settings. Administrative processes that suspend rather than terminate Medicaid enrollment for jail and prison inmates can be helpful.[5]

Interventions that address the unique needs of individuals upon community reentry are thus especially important, particularly for severely-disadvantaged populations that frequently cycle through jails and safety-net psychiatric facilities. Related policies could reach larger populations, as well. For example, state Medicaid programs might reimburse MAT prior to release from jail and prisons, and take other steps to ensure continuity of care.

What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?

Here "do no harm" would be our first priority. Policies that would bar individuals with opioid use disorders from participating in Medicaid, TANF, or other social assistance programs are especially likely to bring unintended harms. We believe, for example, that even though drug testing has a valuable specific role within child protective services and other contexts, population-wide testing may deter opioid users from applying for medical and social services they and their families require.

Families also face significant caregiving burdens when loved-ones experience dual diagnoses, homeless risk, and other severe disadvantages. Some vulnerable individuals seek residential addiction treatment simply because they require housing. This is not a cost-effective use of public resources, and may place states in violation of *Olmstead* requirements. There is a correspondingly acute need for targeted state waivers that deploy Medicaid resources for supportive housing and other models that serve individuals with dual diagnoses, those at-risk of homeless, and other severely disadvantaged populations.

State foster care systems are also strained by the high prevalence of substance use disorders among foster youth, parents, and other family members. Foster care cases have increased substantially in connection to the opioid epidemic, while foster care outlays have declined about 6% (in nominal terms) over the past five years. Additional resources to states pegged to the prevalence of opioid and other substance use disorders are a high priority.

Sincerely

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Fmr. White House drug policy advisor, Bush and Obama Administrations

[5] https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html

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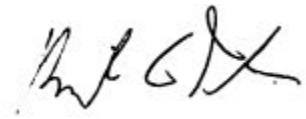

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