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February 14, 2018

Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

SUBMITTED VIA EMAIL

Re: Senate Finance Committee Request for Opioid-Related Policy Recommendations

Dear Chairman Hatch and Ranking Member Wyden:

In response to your letter requesting feedback on eight targeted questions regarding the opioid epidemic, RTI International respectfully submits feedback that may help inform your Committee's deliberations and efforts to provide relief to communities suffering from devastating addiction and overdose.

RTI (www.rti.org/opioids) is a nonprofit research institute headquartered in Research Triangle Park, North Carolina. For more than 30 years, RTI has partnered with the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Office of Assistant Secretary for Planning and Evaluation (ASPE), and other government agencies and private foundations to address the opioid epidemic and improve treatment of pain. Notably, we have collaborated with the Substance Abuse and Mental Health Services Administration (SAMHSA) on the National Survey on Drug Use and Health since 1988 and recently worked with them to update and improve survey questions on opioid use in the United States.

This experience and expertise has informed our response to your request. In short, we recommend Congress focus its efforts to address the opioid epidemic on improving the quality of opioid use disorder treatment. This can be accomplished through the use of quality reporting systems, payment models that emphasize value over volume, and financing that supports a comprehensive approach to treatment and recovery. The paragraphs that follow will lay out three specific recommendations, including background and justification for each.

As you know, despite significant efforts at the federal level to reduce opioid misuse and abuse, opioid deaths continue to rise at alarming rates. While rates of prescription opioids have been declining, millions of Americans are now addicted to opioids because of years of overprescribing of opioids for pain.[1,2] Persons with opioid use disorders face daunting hurdles in finding effective treatment. Moreover, patients and their families have little information in which to select among treatment providers. There are more than 14,000 specialty addiction treatment programs in the US. While some programs are stellar and deliver treatment that has been shown to be highly effective, thousands of other programs offer unproven therapies. For example, despite the evidence that medications are the most effective treatment for opioid use disorders, thousands of addiction

[1] Guy GP Jr, Zhang K, Bohm MK, Losby J, Lewis B, Young R, Murphy LB, Dowell D. Vital Signs: Changes in Opioid Prescribing in the United States, 2006-2015. MMWR Morb Mortal Wkly Rep. 2017 Jul 7;66(26):697-704. doi: 10.15585/mmwr.mm6626a4. PubMed PMID: 28683056; PubMed Central PMCID: PMC5726238.

[2] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

programs purport to be able to effectively treat opioid addictions "drug free" with expensive stays in treatment programs followed by no ongoing treatment or monitoring.[3]

Recommendation #1
Establish a quality reporting system for addiction treatment:

Quality reporting systems improve both the quality and accountability of healthcare providers. The Centers for Medicare and Medicaid Services (CMS) first issued public report cards for nursing homes in 1998—known as Nursing Home Compare—followed by Hospital Compare in 2002. Since then, the CMS Compare Program has expanded to include physicians, home health, dialysis, hospice, inpatient rehabilitative facilities, and long-term care hospitals. Comprehensive reviews of public reporting conclude that health care quality reporting systems provide:

- Immediate value to prospective patients as they can select among care providers, and
- Longer-term value by improving the quality of health care.[4,5,6]

Currently, addiction treatment is not assessed in any type of report card or quality reporting system. Thus, patients lack guidance about which providers are most skilled at offering quality addiction treatment and our health care system lacks data to compare addiction treatment providers and to track whether treatment quality and outcomes are improving over time.

A recent article by RTI's Dr. Tami Mark and colleagues highlights that "[p]ublic-facing rating systems of mental health and addiction providers are already used in other parts of the world, such as in the UK; however, no such system exists to convey the quality of addiction treatment in the US." In this article, Dr. Mark outlines a feasible quality reporting system for addiction treatment.[7] The system could be low-cost to implement and contain high-value information such as addiction treatment wait-times or provider performance in diagnosing, developing a treatment plan and maintaining patients' treatment plans. Such a system could also include patient experience with care. Research shows that patients with substance use disorders who have positive perceptions of care are more likely to have positive treatment outcomes.[8] Thus, an addiction treatment quality reporting system that includes both quality metrics and process outcomes such as wait-times and provider availability coupled with patient experience data could facilitate better and long-lasting treatment outcomes

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[3] Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2016. Data on Substance Abuse Treatment Facilities. BHSIS Series S-93, HHS Publication No. (SMA) 17-5039. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

[4] Mukamel DB, Haeder SF, Weimer DL. Top-down and bottom-up approaches to health care quality: the impacts of regulation and report cards. Annu Rev Public Health. 2014;35:477-97. doi: 10.1146/annurev-publhealth-082313-115826. Epub 2013 Oct 23. Review. PubMed PMID: 24159921.

[5] Totten AM, Wagner J, Tiwari A, O'Haire C, Griffin J, Walker M. Closing the quality gap: revisiting the state of the science (vol. 5: public reporting as a quality improvement strategy). Evid Rep Technol Assess (Full Rep). 2012 Jul;(208.5):1-645. Review. PubMed PMID: 24422977; PubMed Central PMCID: PMC4781596

[6] Emmert M, Schlesinger M. Patients' Awareness, Usage and Impact of Hospital Report Cards in the US. Patient. 2017 Apr 26. doi: 10.1007/s40271-017-0243-y. [Epub ahead of print] PubMed PMID: 28447273.

[7] Mark, T. L., O'Brien, J., Mendell, G., McLellan, A. T., Arsenault, S. (2018). Improving addiction treatment with consumer report cards. Health Affairs Blog, January 5, 2018. https://www.healthaffairs.org/do/10.1377/hauthor20170619.740505/full/

[8] Psychiatr Serv. 2017 Nov 1;68(11):1150-1156. doi: 10.1176/appi.ps.201600484. Epub 2017 Jul 3. Association Between Quality Measures and Perceptions of Care Among Patients With Substance Use Disorders. Hepner KA1, Paddock SM1, Watkins KE1, Ounpraseuth ST1, Schrader AM1, Hudson TJ1.

among individuals with opioid use disorders. Congress should encourage the Department of Health and Human Services and the Substance Abuse and Mental Health Administration (SAMHSA) to build on their existing programs and process, such as the SAMHSA Treatment Locator, to develop an addiction provider rating system that would provide immediately value to patients and their families.[9]

Recommendation #2

Expand financing models that encourage accountability and high-quality addiction treatment:

Addiction treatment financing models must incentivize delivery of the best outcomes for patients at the lowest possible costs. Most healthcare payers in the United States are moving away from paying for volume to paying for value by adopting various types of capitated and bundled payment arrangements that tie payment to outcomes. Under these models, a provider or practice receives a standard payment for an episode of care or to treat an illness over a period of time. The provider is then responsible for ensuring that care is coordinated, comprehensive and leads to positive treatment outcomes. If treatment outcomes are not positive, the provider is financially responsible for the health care costs associated with a patient's ongoing treatment.

In behavioral health, specifically for individuals with opioid use disorders, bundled payments allow providers to be more flexible and offer a broader range of treatment services and supports, such as peer supports, that are often not covered under a traditional fee-for-service payment arrangement but have been shown to be effective and efficient.[10]

The early results of the certified community behavioral health clinics (CCBHCs) demonstration, as well as the results of Medicaid substance use disorder health homes, are promising and suggest that similar models that leverage capitated payment and outcomes reporting can improve the quality and effectiveness of care received by individuals with opioid use disorders.[11,12] However, to date only eight states are participating in the CCHBC demonstration and only a limited number have health homes focused on individuals with addictions. Congress should pass legislation to expand the Certified Community Behavioral Health Center demonstration to more states and to encourage the expansion of opioid health homes under Medicaid.

Recommendation #3

Encourage state Medicaid programs to cover proven recovery support services for individuals with opioid use disorders:

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[9] https://www.findtreatment.samhsa.gov/

[10] Laudet, A. B., & Humphreys, K. (2013). Promoting recovery in an evolving policy context: What do we know and what do we need to know about recovery support services?. Journal of Substance Abuse Treatment, 45(1), 126-133. Clemans-Cope L, Wishner JB, Allen EH, Lallemand N, Epstein M, Spillman BC. Experiences of three states implementing the Medicaid health home model to address opioid use disorder-Case studies in Maryland, Rhode Island, and Vermont. J Subst Abuse Treat. 2017 Dec;83:27-35. doi: 10.1016/j.jsat.2017.10.001. Epub 2017 Oct 6. PubMed PMID: 29129193.

[11] https://www.thenationalcouncil.org/wp-content/uploads/2017/11/National-CCBHC-survey-write-up-FINAL-11-28-17.pdf

[12] Clemans-Cope L, Wishner JB, Allen EH, Lallemand N, Epstein M, Spillman BC. Experiences of three states implementing the Medicaid health home model to address opioid use disorder-Case studies in Maryland, Rhode Island, and Vermont. J Subst Abuse Treat. 2017 Dec;83:27-35. doi: 10.1016/j.jsat.2017.10.001. Epub 2017 Oct 6. PubMed PMID: 29129193.

The American Society of Addiction Medicine (ASAM) maintains that optimal treatment of substance use disorders in general, and opioid use disorders specifically, should adopt a chronic disease model.[7] Under this model, individuals with opioid use disorders are not assumed to be able to fully recover after a short course of treatment. Instead, treatment is structured to acknowledge that relapse is common, particularly early in treatment. Providers monitor patients' symptoms over a period of months (or sometimes years) and tailor their therapy to the patient's changing needs. This is the standard approach to treating chronic, relapsing diseases such as diabetes, asthma, and depression.

Recovery support services help individuals improve their overall functioning in ways that complement substance use disorder treatment. These services are as diverse as the populations they target; some services are psychosocial, such as peer-to-peer counseling or peer-support groups, and others are tied to basic needs, such as housing, transportation, and, in some cases, food.[8] The strongest evidence around recovery support services focuses on recovery housing and peer recovery supports. For example, we know that individuals with substance use disorders living in recovery or supportive housing are more likely to stop and remain abstinent from substance use. We also know that peer support along with social support more generally can help individuals with substance use disorders navigate addiction treatment and remain abstinent after receiving it.

According to the Medicaid and CHIP Payment Access Commission's behavioral health compendium,[13] as of September 2015, fourteen Medicaid programs covered peer supports for individuals with substance use disorders. Recent CMS policy guidance grants states more flexibility to use section 1115(a) demonstrations to expand coverage from the continuum of care for opioid addiction, including recovery and other support services.[14] However, Congress should encourage Medicaid programs to cover recovery support services by offering federal financial coverage for these services, particularly peer and housing support services regardless of states' participation in a section 1115(a) demonstration.

In sum, considering the great need for quality, accessible opioid use disorder treatment, we recommend that Congress focus its efforts to address the opioid epidemic on improving the quality of opioid use disorder treatment.

Sincerely,

Gregory J McDonald

Gregory McDonald
Senior Vice President of Government Relations
RTI International

[13] https://www.macpac.gov/publication/behavioral-health-state-plan-services/

[14] Centers for Medicare & Medicaid Services. (2017, November 1). Strategies to address the opioid epidemic [letter to state Medicaid directors] (SMD No. 17-003). Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf