OTP

Consortium

February 16, 2018

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

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of the Opioid Treatment Program (OTP) Consortium we appreciate the opportunity to provide feedback on how to improve Medicare and Medicaid to respond to the opioid use disorder (OUD) epidemic. The OTP Consortium is a trade association comprised of nearly 350 OTPs across 37 states that provide care to more than 140,000 patients daily in 37 states, including Utah and Oregon.

There are roughly 1,500 OTPs across the United States providing treatment to approximately 400,000 patients. OTPs are highly-regulated, highly-structured, comprehensive treatment programs that provide Medication-Assisted Treatment (MAT). MAT is the most effective solution to treat OUD and OTPs are the only provider where patients are guaranteed to receive MAT. MAT is the integration of medication and psychosocial services to provide individualized care that will have the greatest likelihood of helping people with OUD transition to recovery and lead healthy, socially-productive lives. More specifically, OTPs provide medication, individual and group counseling, random drug testing and other supportive services such as case management, primary care, mental health services, HIV and Hepatitis C testing and more.

The benefits of MAT are substantial and have been proven repeatedly through rigorous scientific studies for more than 50 years: MAT has been shown to improve patient survival, increase retention in treatment, decrease opioid use and criminal activity, increase patients' ability to gain and maintain employment, improve birth outcomes among women who have substance use disorders and are pregnant, and lower a person's risk of contracting HIV or Hepatitis C by reducing the potential for relapse.[1] Those who receive MAT are 75% less likely to have an addiction-related death than those who do not receive MAT.[2] Unfortunately, Medicare and Medicaid coverage of MAT services is severely lacking.

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[1] https://www.samhsa.gov/medication-assisted-treatment/treatment

[2] Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, SAMHSA, 2008.

There are three federally-approved medications to treat opioid use disorder, all of which should be used in conjunction with psychosocial services: methadone, buprenorphine, and extended release injectable naltrexone. Despite the National Institutes of Health stating that, "the safety and efficacy of MAT has been unequivocally established. …methadone maintenance coupled with relevant social, medical and psychological services has the highest probability of being the most effective of all treatments for opioid addiction,"[3] Medicare does not cover methadone for the treatment of OUD and many Medicaid programs fail to cover all three approved medications.

It is important to note that buprenorphine, methadone, and naltrexone are not proverbial "silver bullets." Despite the claims by some, medication alone generally does not lead to recovery. The medication simply assists the treatment by stabilizing the patient. These patients need counseling and other supportive services to assure successful outcomes. It is critical that these services are also covered.

We hope this background information is helpful to you has you consider the OTP Consortium's responses to your specific questions:

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

According to CMS, 30% of Part D enrollees used prescription opioids in 2015.[4] So it is not surprising that more than 300,000 Medicare beneficiaries have been diagnosed with opioid use disorder.[5] Moreover, Medicare beneficiaries have the highest and fastest growing rate of OUD.[6] Alarmingly, Medicare hospitalizations due to complications caused by opioid abuse or misuse increased 10% every year from 1993 to 2012.[7]

While Medicare pays for the pain medications that are contributing to the OUD epidemic, it does not pay for the full range of treatment options necessary to treat beneficiaries' addiction. Specifically, Medicare leaves out of the continuum of care for opiate treatment the most inexpensive, the most structured outpatient venue, and the most researched with proven efficacy of MAT - the SAMHSA-certified OTP. OTPs are the only treatment sites that can provide all three medications including methadone, buprenorphine and injectable extended release naltrexone and the only treatment site for MAT that, by regulation, mandates the use of evidenced-based counseling in combination with medication.

[3] "Confronting an Epidemic: The Case for Eliminating Barriers to Medication-Assisted Treatment of Heroin and Opioid Addiction," Legal Action Center, March 2015.
[4] CMS Announcement of Calendar Year 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, page 216
[5] Ibid.
[6] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2535238
[7] Ibid.

Furthermore, no single medication works for all people so having the full range of FDA-approved proven treatment options is essential for mitigating the vast harms caused by the current opioid epidemic. Instead, Medicare will pay for "treatment" with more expensive medications in what are often times less-effective settings.

Medicaid beneficiaries have OTP MAT coverage. TRICARE beneficiaries have access to MAT in the OTP setting. Yet, Medicare beneficiaries do not, unless they are willing to pay out-of-pocket for treatment. President Trump's Commission on Combating Drug Addiction and the Opioid Crisis recommended that HHS and CMS "remove reimbursement and policy barriers to SUD treatment, including those… that limit access to any forms of FDA-approved medication-assisted treatment."[8] We urge Congress to enact legislation to provide Medicare beneficiaries with access to MAT in the OTP setting that incorporates all federally-approved medications to treat OUD.

Congress can look to Medicaid and TRICARE when designing a Medicare OTP benefit. Specifically, we recommend that Medicare adopt a bundled payment methodology where all MAT-related services and medications provided in the OTP setting are reimbursed under a unified, fair capitated rate. The bundled model has proven to be successful in Medicaid and TRICARE and could be quickly implemented by the 1,500 OTPs across the country – ensuring timely access to life-saving treatment for Medicare beneficiaries. The OTP Consortium stands ready to work with this committee and your colleagues in Congress to design, advocate for, and implement this long-overdue coverage option.

In terms of Medicaid coverage, we fully endorse President Trump's FY19 budget proposal to require that "state Medicaid programs cover all FDA-approved Medication Assisted Treatments for opioid use disorder, including counseling and other costs,"[9] in OTPs. The White House Office of Management and Budget estimates this policy change would save $865 million in federal spending over the next 10 years.[10] According to the American Society of Addiction Medicine, just 28 states covered the three FDA-approved medications used in MAT in 2014.[11]

Adding Medicare coverage for MAT in the OTP setting and requiring Medicaid cover all federally-approved medications in the OTP setting would ensure that patients suffering from OUD have access to form of treatment that is most likely to lead to recovery. Not only will such a change save lives, it will also save taxpayer money.

[8] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf
[9] https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf
[10] Ibid.
[11] https://www.asam.org/resources/publications/magazine/read/article/2014/08/15/state-medicaid-coverage-of-addiction-treatment-in-the-us

We also support collecting data on those providing treatment for patients suffering from OUD. Specifically, OTPs and DATA 2000 practices should be required to report on their prescribing practices, frequency with which they see the patient, frequency with which the patient receives counseling and from whom (in-house or via referral), frequency with which random toxicology testing is administered, percentage of patients that received a prescription drug monitoring program (PDMP) query in the last 30 days, percentage of patients that were subject to a random medication "call back" within the last 30 days, treatment retention rates, patient mortality rates, percentage of patients with opioid positive drug screen results, percentage of patients with non-opioid positive drug screen results, and the average monthly patient caseload for each provider. This data, which reflects best practices, will inform policymakers as to the type of OUD treatment being provided and whether or not its successful.

4. Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?

We support the Centers for Medicare & Medicaid Services' efforts to limit the quantity of pills dispensed with each opioid pain medication prescription. We also support pharmacy lock-in efforts as an additional means of ensuring appropriate use of opioid pain medications.

5. How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

Those prescribing or administering opioids to Medicare and Medicaid beneficiaries should be required, not just encouraged, to check PDMPs before issuing the prescription. Currently, just 19 states require prescribers to check a PDMP when writing an initial prescription for opioid pain medication.[12] Ensuring that all providers access PDMPs would significantly reduce the number of inappropriate prescriptions that have largely contributed to the OUD epidemic.

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

State PDMPs should be interoperable so that patients cannot bypass prescription limits or restrictions by filling prescriptions in neighboring states. Congress could encourage such efforts by tying interoperability to Medicaid FMAP reimbursement.

[12] http://www.pewtrusts.org/en/multimedia/data-visualizations/2018/when-are-prescribers-required-to-use-prescription-drug-monitoring-programs

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

As part of MAT, states require OTPs to provide counseling and random toxicology screening to OUD patients. Often times, these services are required to be more frequent at the beginning of therapy. These requirements are important as they ensure that patients are getting real treatment. Unfortunately, these evidence-based requirements are not required of office-based providers. We believe that any provider who prescribes, dispenses, or administers buprenorphine or naltrexone for MAT should be required to ensure their patients receive regular psychosocial services and random toxicology screening.

Also, some states have adopted an innovative "hub and spoke" model of delivering MAT to those suffering from OUD. Under this model, the specialized OTPs serve as the "hub" and federally-qualified health centers, mental health centers, and office-based providers serve as the "spokes." The regional hubs provide high-intensity MAT through staff that are specialized in addiction treatment and consult and train the spokes that are dispersed throughout the community. When the spokes need assistance with complicated patients, the hubs serve as an excellent resource to provide specialized care and treatment advice to the less-specialized spokes. There is a free flow of patient information between the hub and spokes to ensure coordinated care. The hub and spoke model expands access to rural areas and to areas with high rates of OUD. California and Vermont are currently operating successful hub and spoke treatment models.

We appreciate your consideration of these comments and look forward to working with the Committee on these issues going forward. If we can provide any additional information, or otherwise serve as a resource on these important issues, please do not hesitate to contact Dan Elling at (202) 448-1644 or dan@lpgdc.com.

Sincerely,

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