The Opioid Crisis: Removing Barriers to Prevent and Treat Opioid Abuse and Dependence in Medicare

Testimony of
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Chairman Roskam, Ranking Member Levin, and members of the subcommittee, I appreciate the opportunity to testify today about the opioid epidemic that is ravaging our country and important steps this committee can take to help address this crisis. I want start by thanking all of you for your interest and attention to this important issue.

I am doctor Jason Kletter, President of Baymark Health Services. BayMark, which is headquartered in Lewisville, TX, currently provides treatment for opioid use disorder (OUD) using medication-assisted treatment (MAT) and outpatient detoxification services in 95 facilities across 26 states – including Alabama, California, Florida, Illinois, Minnesota, Nebraska, Pennsylvania, and Texas. We are the largest organization in the country focused primarily on treatment services for opioid use disorder. We provide treatment services across three modlaities: licensed opioid treatment programs, less-structured office-based services and outpatient detoxification combined with extended recovery support services. Each day, we treat over 33,000 patients in their recovery from opiate dependence and addiction. Our nation faces an unprecedented epidemic of opiate use, and BayMark works hard every day to expand accesst to high-quality, evidence-based services to those who need them.

I currently serve on the board of the American Association for the Treatment of Opioid Dependence (AATOD). I am also the President of the California Opioid Maintenance Providers group, have served as advisor to the California Department of Health Care Services on many committees including the Narcotic Treatment Program Advisory Committee, the California Outcome Management System Workgroup, the Counselor Certification Advisory Committee and the Continuum of Services System Redesign. I have also participated in Federal Center for Substance Abuse Treatment initiatives, advising on accreditation guidelines and evaluating training curricula for opioid treatment program (OTP) physicians. All told, I have 25 years of experience in OUD treatment, including front-line positions such as health worker and counselor and many administrative roles including corrections contract manager and Human Resource Director. I am also here today on behalf of the OTP Consortium, a trade association comprised of more than 300 OTPs across 37 states.

Given that it is impossible to open a newspaper, turn on a TV or check social media and not be overwhelmed with news about our nation's opioid epidemic, I won't spend a lot of time reciting the grim statistics; I know everyone on this Committee is familiar with the scale and scope of this crisis. I will, however, highlight just two data points that I think are among the most shocking: First, according to the Centers for Disease Control and Prevention, opioids (including prescription opioids, heroin, and fentanyl) killed more than 42,000 people in 2016, more than any year on record. That's about 115 people each day in our country – these people are our family, friends, neighbors, and coworkers.

The second data point that warrants special attention is, according to a report from the White House Council of Economic Advisors, in 2015, the economic cost of the opioid crisis was $504.0 billion, or 2.8% of the gross domestic product that year.[1]

So, the data tells us that not only are massive numbers of people being killed by this epidemic, but it is diminishing our nation's resources and costing us very real dollars.

Of course, these shocking statistics do nothing to describe the devastating effects on our families, neighborhoods and communities across the nation.

Opioid Use Disorder is a Disease

I want to be sure that you all are familiar with the current, state-of-the-art science about opioid use disorder. OUD is regarded by experts to be a disease of the brain, not a lack of will power or a moral downfall. Advances in technology over the past several decades have allowed scientists a better understanding of the impacts of drug use and the root cause of the behaviors that manifest from people with OUD. Alan Leshner, a former Director at the National Institute of Drug Abuse (NIDA) wrote in 2001:

> *"A core concept that has been evolving with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs. The consequence is virtually uncontrollable compulsive drug craving, seeking, and use that interferes with, if not destroys, an individual's functioning in the family and in society."*[2]

In addition, NIDA noted, "addiction affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior."[3]

This concept of OUD as a chronic, relapsing disease is essential to understanding successful treatment solutions.

Medication-Assisted Treatment

The most effective solution we have for treating OUD is medication-assisted treatment (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. 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.

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[1] The Underestimated Cost of the Opioid Crisis, Council of Economic Advisors, November 2017.

[2] Leshner, A. I. (2001). Addiction is a brain disease. *Issues in Science and Technology, XVII*, 3. Dallas, TX.

[3] NIDA. (2009). *Drug facts: Treatment approaches for drug addiction*. Retrieved from http://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction

Agonist medications like methadone and buprenorphine help to stabilize the patient so that they can effectively participate in counseling, case management and other services that lead to recovery. Naltrexone is an antagonist that blocks the effects of opioids.

However, 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. These patients need counseling and other supportive services to assure successful outcomes.

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.[4] Those who receive MAT are 75% less likely to have an addiction-related death than those who do not receive MAT.[5]

Opioid Treatment Programs

There are roughly 1,500 Opioid Treatment Programs or "OTPs" across the United States providing treatment to approximately 400,000 patients. OTPS are highly-regulated, highly-structured, comprehensive treatment programs that provide MAT. 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.

Much of the OTP regulations are intended to prevent diversion of the powerful medications used as part of MAT. For example, our skilled nurses administer the medication to patients each day until patients are able to demonstrate stability and progress in treatment, as measured in part by random drug tests. In this way, we can be certain that the medication is not being sold on the street, unlike other sites of care, where a physician may write a prescription for 30 days and have no ability to ensure the intended person is using the medication as directed. As a result of this highly-regulated structure, diversion from OTPs is very limited. Daily medication administration also has therapeutic value, allowing compassionate, trained medical staff to briefly assess patients daily and provide information and words of encouragement to retain them in treatment.

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

[5] 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.

At BayMark, about 85% of our 33,000 patients are administered methadone, another 14% are provided buprenorphine, and the remaining 1% receive extended release naltrexone. Which medication each patient receives as part of MAT on their path to recovery is determined on an individual basis as part of the assessment and history of drug use identified during a collaborative process between the patient and his/her physician.

Methadone for Treatment Purposes

Methadone has been used for more than 50 years, has been rigorously researched and is considered to be the "gold standard" in the treatment of opiate dependence. In fact, the American Society of Addiction Medicine states that the efficacy and safety profile of MAT with methadone in the OTP setting "has been solidly and repeatedly established in the clinical outcomes literature since 1965."[6]

Methadone is highly regulated, as it should be, and can only be dispensed for OUD by clinics that have been certified to treat OUD by the Substance Abuse and Mental Health Services Administration, the Drug Enforcement Adminsitration and others. Methadone blocks the effects of heroin and prescription drugs containing opioids while eliminating withdrawal symptoms and relieving drug cravings. It is an excellent medication when used as part of MAT, with patients having very high retention and success rates.

Proven Track Record

As discussed in SAMHSA's TIP 43, research has shown that retention in treatment over an extended period of time is essential for positive outcomes with OUD, just as it is with other chronic diseases such as diabetes, hypertension and asthma.[7]

At BayMark, about 61% of our patients are retained in treatment for at least 90 days. Furthermore, while 100% of our patients are using opioids multiple times each day at admission, about 50% of our patients in treatment less than 30 days are free of opioids. That number jumps to 60% for patients in treatment 3-6 months, 68% for patients in treatment 6-9 months, and 82% for patients in treatment more than one year. This is proof that MAT delivered in an OTP is saving hundreds of thousands of lives.

[6] https://www.asam.org/docs/default-source/public-policy-statements/1obot-treatment-7-04.pdf?sfvrsn=0

[7] McLellan, A.T.; Lewis, D.C.; O'Brien, C.P.; and Kleber, H.D. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. JAMA 284(13):1689–1695, 2000.

Medicare Coverage Policy is a Barrier to Access

According to CMS, 30% of Part D enrollees used prescription opioids in 2015.[8] So we should not be surprised that more than 300,000 Medicare beneficiaries have been diagnosed with opioid use disorder.[9] Moreover, Medicare beneficiaries have the highest and fastest growing rate of OUD.[10] Alarmingly, Medicare hospitalizations due to complications caused by opioid abuse or misuse increased 10% every year from 1993 to 2012.[11]

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 does not cover comprehensive treatment services in OTP specialty care settings. This would be equivalent to covering insulin for diabetics without covering glucose monitoring or educational services intended to improve diet and other behaviors. Furthermore, no single medication works for all people so having a range of 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. The average reimbursement for MAT in an OTP is roughly $500 per month while average reimbursement for similar treatment in an office-based environment is roughly $800-$1,000 per month, largely because buprenorphine is more expensive than methadone.

Medicaid beneficiaries have OTP coverage. TRICARE beneficiaries have access to treatment in the OTP setting. Yet, Medicare beneficiaries do not, unless they are willing to pay out-of-pocket for treatment. At BayMark, we estimate that between five and seven percent of our patients are Medicare beneficiaries, which is consistent with the rest of the industry.

[8] CMS Announcement of Calendar Year 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, page 216

[9] Ibid.

[10] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2535238

[11] Ibid.

What Can Congress Do?

In the 2017 Medicare Advantage and Part D Advance Notice and Call Letter, CMS sought comments about whether Medicare's methadone coverage policy "is a barrier to treatment."[12] In the final rate notice, CMS said "absent a change in law, Medicare is unable to cover methadone for MAT under Medicare Part B or Part D. However, under Part C, [Medicare Advantage] organizations may cover methadone for MAT as a supplemental benefit."[13] More recently, 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."[14]

Given the current public health emergency stemming from opioid addiction, and the rapidly rising number of Medicare beneficiaries suffering from OUD, we respectfully request that Congress pass legislation to provide Medicare beneficiaries with coverage for MAT with all FDA-approved medications to help treat OUD in the OTP setting.

Recommended Medicare Benefit Structure

Congress can look to Medicaid and TRICARE when designing a Medicare OTP benefit. Specifically, BayMark, AATOD, and the OTP Consortium recommend that Medicare adopt a bundled payment methodology where all MAT-related services provided in the OTP setting, in addition to any medications provided, are reimbursed under a unified, fairly reimbursed 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. BayMark, AATOD and the OTP Consortium stand ready to work with this committee and your colleagues in Congress to design, advocate for, and implement this long-overdue coverage option.

Conclusion

In closing, I want to thank you for your concern and your attention to this matter. While our country is in the throes of a tragic epidemic, the silver lining here is that we have very effective treatment and a dedicated and compassionate workforce ready and able to save lives and rebuild communities.

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[12] CMS Advance Notice of Methodological Changes for CY 2017 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter, page 205.

[13] CMS Announcement of Calendar Year 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, page 208

[14] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf