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February 16, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Orrin Hatch
Chair
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

Re: Senate Finance Committee Letter Requesting Input on Addressing Opioid Epidemic

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the National Health Law Program (NHeLP), we thank you for the opportunity to provide recommendations to the Senate Finance Committee on ways in which Congress can act to address the opioid overdose epidemic. NHeLP protects and advances the health rights of low income and underserved individuals. Founded in 1969, NHeLP advocates, educates and litigates at the federal and state level. The following recommendations focus on efforts to mitigate the impact of Substance Use Disorders (SUD) and Opioid Use Disorders (OUD) among low-income individuals, in particular those enrolled in Medicaid.

According to the CDC, more than 63,600 individuals died due to a drug overdose in 2016, more than any year on record. Drug overdose is now the leading cause of accidental deaths in the U.S., surpassing the number of deaths resulting from auto collisions and the number of gun-related deaths. The opioid epidemic now kills more individuals than HIV/AIDS did at the height of that epidemic in the 1990's.

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Low-income individuals are disproportionately affected by drug overdoses and Medicaid is a valuable tool in the fight against the epidemic. It is estimated that nearly 12% of adults in Medicaid and 6% of children and adolescents have an SUD, a higher percentage than adults and adolescents with SUD in the general population (8.5% and 5%, respectively).[1] Moreover, of the 20.2 million adults in the U.S. with an SUD, 23% are covered by Medicaid, making the program **the single largest source of insurance coverage for individuals with SUD**.[2]

The majority of these Medicaid beneficiaries are currently receiving SUD and OUD services as a direct result of the Affordable Care Act's (ACA) Medicaid expansion. As of 2016, 1.2 million individuals with an SUD have gained coverage in states that adopted the expansion and as many as 1.1 million more would get coverage if the remaining states expanded Medicaid.[3] Largely because of the Medicaid expansion, the share of people below 400% of the federal poverty level foregoing mental health care because they cannot afford it decreased by about 25% between 2010 and 2015.[4]

Not only does Medicaid cover a vast number of individuals with behavioral and substance use conditions, but Medicaid also provides comprehensive coverage of SUD and OUD services. Medicaid coverage of mental health and SUD services is generally more extensive than private coverage and includes Medication Assisted Treatment (MAT) and the overdose-reversal medication naloxone.[5] MAT, which consists of pharmacotherapy (often in conjunction with behavioral therapy), is the evidence-based standard for OUD treatment. Treatment with methadone and buprenorphine has been proven effective in mitigating the negative effects of OUDs.[6] Under the ACA's essential health benefits provisions, all Medicaid expansion individuals are now eligible for buprenorphine

[1] Centers for Medicare and Medicaid Services, Reducing Substance Use Disorders, https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/reducing-substance-use-disorders/reducing-substance-use-disorders.html; Substance Abuse and Mental Health Services Admin., Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health, September 4 2014, https://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf; Substance Abuse and Mental Health Services Admin., Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, September 2015, https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.

[2] Mir M. Ali et al., *State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for uninsured individuals with a behavioral health condition*, November 18, 2015, https://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.pdf. *See also* Susan H. Busch et al., *Characteristics of Adults with Substance Use Disorders Expected to Be Eligible for Medicaid Under the ACA*, 64 Psychiatric Services 520–526 (2013); Deborah Bachrach et al., *Medicaid: States' Most Powerful Tool to Combt the Opioid Crisis*, July 2016, http://statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf.

[3] Mir M. Ali et al., *supra* at 2.

[4] *Id.*

[5] Ken Cannon et al., *Adult behavioral health benefits in Medicaid and the marketplace*, Kaiser Family Foundation, June 11, 2015, http://kff.org/medicaid/report/adult-behavioral-health-benefits-in-medicaid-and-the-marketplace/.

[6] *See*, for example, Wayne Hall et al., *Effectiveness of MMT on Heroin Use and Crime*. Harwood Academic Publishers (1998); Bennett W. Fletcher & Robert J. Battjes, *Introduction to the Special Issue: Treatment Process in DATOS*, 57 Drug and Alcohol Dependence 81 (1999); Monique E. Wilson et al., *Impact of Interim Methadone Maintenance on HIV Risk Behaviors*, 87 J Urban Health 586 (2010); Linda Gowing et al., *Oral Substitution Treatment of Injecting Opioid Users for Prevention of HIV Infection*, 8 Cochrane Database of Systematic Reviews CD004145 (2011); Robert P. Schwartz, et al., *Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995–2009*, 103 Am J Public Health 917 (2013); and Catherine A. Fullerton et al., *Medication-assisted treatment with methadone: assessing the evidence*, 65 Psychiatric Serv. 146 (2014).

treatment and, in most states, methadone treatment.[7] Similarly, since the ACA was enacted, all 50 state Medicaid programs have expanded coverage of naloxone, a medication that has resulted in over 26,000 overdose reversals since 1996.[8]

We urge the Senate Finance Committee to consider the value of Medicaid and the needs of low-income individuals as it evaluates approaches to address the opioid overdose epidemic. Specifically, we recommend:

- **Preserving Medicaid's financing structure and ensuring continued and sufficient federal funding to support Medicaid expansion as currently available.** Given the importance of Medicaid in preventing and treating OUDs, any cuts made to Medicaid funding would severely harm the efforts to curb the opioid epidemic. For instance, ending the Medicaid expansion or changing the way Medicaid is financed, including converting Medicaid funding to per-capita-caps or block grants, would eliminate $5.5 billion each year from SUD treatment.[9] In addition, repealing the Medicaid expansion or capping federal Medicaid funding would lead states to restrict Medicaid eligibility for low-income adults with SUD or to impose onerous requirements on access to SUD treatment, such as prior authorization for buprenorphine or methadone treatment, simultaneous counseling requirements, and/or subjecting individuals to "lock-in" programs. These onerous requirements would prevent Medicaid beneficiaries from accessing services that reduce the risk of overdose.

- **Continuing and strengthening the recent shift of efforts to combat the opioid epidemic from an emphasis on law enforcement to an increased emphasis on OUD treatment.** In a groundbreaking report released in 2016, the Surgeon General called for a shift in the public response to the epidemic from an emphasis in law enforcement to public health-based interventions.[10] The report commended the previous administration's effort to place non-violent drug offenders in treatment instead of jail. The report also emphasized the importance of early intervention and increasing access to MAT for people with SUD, instead of criminal prosecutions, as the most effective way of reducing the impact of the epidemic. We urge the Committee to continue supporting efforts to increase access to prevention and treatment services and to oppose the current administration's focus on law enforcement while neglecting access to care for low-income individuals with SUD.

- **Ensuring appropriate funding for programs authorized by the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act.** Both CARA and the Cures Act passed with overwhelmingly bipartisan support. These statutes provide authorization for grants to state and local

[7] Colleen M. Grogan et al., *Survey Highlights Differences in Medicaid Coverage for Substance Use Treatment and Opioid Use Disorder Medications*, 35 Health Affairs, 2289, 2292 (2016).
[8] Eliza Wheeler et al., *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons – United States, 2014*, 64 Morbidity and Mortality Weekly Rep. 631 (2015).
[9] Richard G. Frank & Sherry A. Glied, *Keep Obamacare to Keep Progress on Treating Opioid Disorders and Mental Illnesses.* The Hill, January 11, 2017, http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders.
[10] U.S. Dep't of Health and Human Services, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, 2016, https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf.

governments for, among other activities, expanded access to MAT and naloxone, establishment and maintenance of prescription drug monitoring programs (PDMPs), establishment of jail diversion programs, and educational activities. While Congress has appropriated funding for some of these programs, funding must be continuously appropriated and secured for the duration of the activities. CARA and the Cures Act authorized funding for several programs until 2022. It is imperative that the Senate Finance Committee demonstrate a commitment to the programs approved by Congress, which are essential tools for state and local governments to continue fighting the epidemic through evidence-based practices.

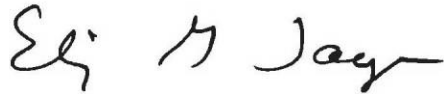
- **Supporting enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).** The MHPAEA generally requires most health insurance plans, including Medicaid plans, to treat mental health and SUD benefits on equal footing as medical and surgical benefits. While the act represents an important achievement for mental health parity, enforcement continues to lag behind. Through the Cures Act, Congress sought to strengthen and increase enforcement of the mental health parity requirements by authorizing the Department of Health and Human Services, the Department of Labor, and the Department of Treasury to release compliance guidance and audit health plans to assess compliance. We urge the Committee to demonstrate a commitment to mental health parity by supporting and overseeing these agency activities in order to increase compliance with the requirements of the MHPAEA.

- **Supporting Medicaid innovation waivers that seek to expand access to treatment and to increase integration of behavioral health services with physical health.** In 2015, the Centers for Medicaid and Medicare Services (CMS) encouraged states to request demonstration authority through section 1115 of the Medicaid Act for programs that seek to address the opioid epidemic among Medicaid beneficiaries. Among other things, states were encouraged to seek expansion of MAT and naloxone availability and integration of behavioral and mental health services with other services provided by Medicaid. While several states have requested demonstration approval along these lines, only a few states have embraced a comprehensive approach to OUD treatment.

  For example, in 2015 California began its Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration program, which seeks to increase the availability of MAT by strengthening coordination between Medicaid managed care plans and mental health plans. The program also ensures that patients with more serious SUDs are receiving treatment with buprenorphine by incorporating the HUB and Spoke model to OUD treatment. This model, first implemented in Vermont, enables federally qualified health centers (FQHCs), mental health centers, or community clinics to serve as coordination centers (spokes) for narcotic treatment programs (hubs), which provide high intensity MAT. We urge the Committee to support similar demonstration programs proposed by other states and to oppose the current administration’s approval of illegal and harmful waivers that will increase the burden of the opioid epidemic, such as those that seek to implement work requirements and drug testing on Medicaid beneficiaries.

Thank you for your attention to our comments. NHeLP urges the Senate Finance Committee to focus its attention on ways to strengthen Medicaid's vital role in providing life-saving services for low-income individuals with SUD. Any action that weakens the Medicaid program will inevitably contribute to more overdose deaths and will prolong the effects of the opioid epidemic. If you have any questions or need further information, please contact Héctor Hernández-Delgado (hernandez-delgado@healthlaw.org) at the National Health Law Program.

Sincerely,



Elizabeth G. Taylor
Executive Director