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October 11, 2019

Alex M. Azar II
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Seema Verma
Administrator, Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

**Re: Request for Information for the Development of a CMS
Action Plan to Prevent Opioid Addiction and Enhance
Access to Medication-Assisted Treatment**

Dear Secretary Azar and Administrator Verma:

The National Health Law Program (NHeLP) appreciates the opportunity to provide feedback on ways in which the Centers for Medicare and Medicaid Services (CMS) can address the opioid crisis through the development of an Action Plan as required under Section 6032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT Act"). NHeLP is a public interest organization working to advance access to quality health care and protect the legal rights of low-income and under-served people.

Our comments broadly address the questions posed in the RFI. In general, we strongly refute any notion that expanding coverage through Medicaid for low-income individuals has in any way contributed to the opioid crisis. In fact, Medicaid has played an important role in reducing the burden of the epidemic and improving access to treatment for people with substance use disorder (SUD), including opioid use disorders (OUD). In addition, Medication-Assisted Treatment (MAT) is the gold standard of care for treating SUD. CMS must remove all barriers to accessing MAT and the overdose-reversal medication naloxone for Medicaid beneficiaries, as these are essential tools to address the opioid crisis.

1. Medicaid is vital in the fight against the opioid epidemic.

States that expanded Medicaid have experienced significant increases in the number of people accessing SUD prevention and treatment services in the years following the expansion. The ACA's essential health benefit (EHB) requirement has made prevention and treatment services available to this population, as states must provide EHBs to the new enrollees. Medicaid now represents the single largest source of insurance coverage for behavioral health services and SUD treatment.¹ As of 2016, 1.2 million individuals with SUD have gained coverage in states that adopted the expansion; as many as 1.1 million more individuals with SUD would gain access to such coverage if the remaining states expanded Medicaid.² Largely because of the Medicaid expansion, the share of people below 400% of the federal poverty level foregoing behavioral health care because they cannot afford it decreased by about 25% between 2010 and 2015.³

The Medicaid expansion has particularly benefitted the states hardest hit by the opioid epidemic. For example, Kentucky, Ohio, and West Virginia have some of the highest rates of SUD and opioid-related overdose deaths in the country. These states have all expanded Medicaid, which now covers over 20% of the population in each of the three states and has become an increasingly important source of coverage for adults with SUD.⁴ In Ohio, almost 500,000 individuals, over 50% of all newly insured individuals, have received SUD services since the state expanded Medicaid eligibility.⁵ These states have also seen in the largest drop in the uninsurance rate among individuals hospitalized for an opioid-related condition.

At the same time, studies have demonstrated that the Medicaid expansion has not caused an increase in the number of people overusing opioid medications for pain.⁶ Evidence indicates that states with the largest share of OUD and OUD-related hospitalizations had been

¹ Deborah Bachrach et al., Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis, July 2016, <http://statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Toolto-Combat-the-Opioid-Crisis-July-2016.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).

³ Ali et al., *supra*.

⁴ Kaiser Family Foundation, Health insurance coverage of the total population, 2015, <http://kff.org/other/stateindicator/total-population/?currentTimeframe=0>.

⁵ Catherine Candisky & Alan Johnson, Medicaid expansion covers nearly 500, 000 Ohioans for mental health, drug treatment, *The Columbus Dispatch*, July 17, 2016, <http://www.dispatch.com/content/stories/local/2016/07/17/medicaid-expansion-covers-nearly-500000-for-mentalhealth-drug-treatment.html>.

⁶ Center on Budget and Policy Priorities, Medicaid Expansion Dramatically Increased Coverage for People with opioid-Use Disorders, Latest Data Show, Feb. 28, 2018, <https://www.cbpp.org/research/health/medicaid-expansion-dramatically-increased-coverage-for-people-with-opioid-use>.

experiencing higher rates since the years before the Medicaid expansion.⁷ In fact, it is likely because of the high rate of OUD these states had been experiencing that they decided to expand Medicaid as a vehicle to address the epidemic. After the expansion, the share of opioid-related hospitalizations increased at a similar rate in expansion and non-expansion states. Moreover, some evidence shows that prescription opioid use has actually decreased in states that expanded Medicaid, likely due to the comprehensive nature of Medicaid coverage and the availability of additional services to treat or address pain and OUD.⁸

2. CMS should discourage the use of Medicaid opioid coverage limits as a tool to decrease OUD.

In the past couple of years, an increasing number of states have resorted to opioid prescribing limits as a way to prevent development of OUD, particularly around opioids prescribed for treatment of acute pain. Many states have applied such limits only to Medicaid coverage of opioid medications for pain, creating disparities between low-income individuals and other populations when it comes to treating pain. For several reasons, we caution that such strict limits on coverage of opioid prescriptions may act in a counterproductive way by increasing opioid dependence and by failing to effectively address the need for SUD and OUD treatment. While limits on Medicaid coverage of opioids for pain may lead to a decrease in the number of opioid prescriptions, there is no guarantee that it will result in a reduction of opioid-related harm, which should be the primarily goal of any such measure. This is particularly true in states that fail to adopt further measures like the ones outlined below, such as expansion of coverage of non-opioid alternatives for pain treatment and expansion of coverage of SUD and OUD treatment.

In addition, such limits often result in unintended consequences for low-income beneficiaries, and particularly people with disabilities who live with chronic pain. Many of these individuals are currently receiving opioids for pain management and, as some have experienced already, limiting the amount of opioid prescriptions covered under Medicaid may lead providers to curtail medically necessary care and to nonconsensually discontinue opioid therapy due to unfounded fears that the patient may develop an OUD. In fact, the authors of the 2016 CDC opioid prescribing guidelines recently recognized that providers have been misapplying the guidelines by inappropriately cutting patients' opioid prescriptions.⁹ These guidelines should never substitute for clinical judgment and should not limit Medicaid coverage of medically necessary care. In addition, for many patients who need opioids, Medicaid coverage limits will lead to unaffordable out-of-pocket costs because of the need for additional prescriptions and office visits as well as payments for prescriptions that exceed the amount allowable under Medicaid. We urge CMS to discourage state use of any such limits imposed on Medicaid

⁷ *Id.*

⁸ See Julia O'Donoghue, *In Louisiana, is Medicaid expansion fueling the opioid crisis? That's hard to prove*, NOLA.com, Nov. 11, 2017, https://www.nola.com/news/politics/article_f6cf73c9-aef0-5740-8366-2e446b24a9fc.html.

⁹ Deborah Dowell, et al., *No Shortcuts to Safer Opioid Prescribing*, *N Engl J Med* 2019; 380:2285-2287, June 13, 2019, <https://www.nejm.org/doi/full/10.1056/NEJMp1904190>.

coverage and to call on states to find alternative and more effective measures to prevent development of SUD and OUD.

3. CMS should encourage Medicaid coverage of non-opioid alternatives to treat pain to decrease the use of opioids.

Instead of inappropriately curtailing already established regimes of opioid medications for pain, states should make sure providers have a full array of tools available to treat acute and chronic pain. This would include access to opioids when medically necessary, but should also include Medicaid coverage for non-opioid services to treat pain, such as physical therapy, acupuncture, chiropractic care, and over-the-counter medications.¹⁰ States can expand coverage to such services through a State Plan Amendment (SPA) and without the need to request a Section 1115 demonstration waiver. As such, we believe CMS should, as part of the new Action Plan, encourage states to expand Medicaid coverage to non-opioid treatment alternatives and to encourage removal of coverage limitations, such as prior authorization requirements, in order to make these services accessible and a reliable option for providers and beneficiaries.

4. CMS should encourage states to remove all barriers to MAT and naloxone coverage and should improve enforcement of the parity requirements for Medicaid plans.

MAT, particularly treatment with the medications methadone and buprenorphine, is the gold standard of care for treating individuals with SUD and has been proven effective in reducing the burdens associated with SUD and OUD.¹¹ Similarly, the overdose-reversal medication naloxone has been responsible for reverting countless opioid-related overdoses and thus for saving thousands of lives since being introduced in market.¹² As such, CMS should encourage states to make these medications easily available for all Medicaid beneficiaries. This means that states should work to remove all policy barriers that impede coverage of these medications, such as prior authorization requirements, simultaneous counseling requirements, and/or subjecting individuals to “lock-in” programs. These onerous requirements prevent Medicaid beneficiaries from accessing services that reduce the risk of overdose. While pursuant to the ACA’s EHB requirement some states already make these medications available without constraints, barriers still remain in place in several states, hampering efforts to address the opioid crisis.

¹⁰ Casey Ross, *As the opioid crisis grows, states are opening Medicaid to alternative medicine*, STAT News, Jan. 17, 2018, <https://www.statnews.com/2018/01/17/medicaid-opioids-alternative-medicine/>.

¹¹ Corey Davis, Carli Suba, & Amy Lieberman, *Medication-Assisted Treatment for Opioid Use Disorder: The Gold Standard*, National Health Law Program, May 16, 2018, <https://healthlaw.org/resource/medication-assisted-treatment-for-opioid-use-disorder-the-gold-standard/>.

¹² Eliza Wheeler et al., *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons – United States, 2014*, 64 *Morbidity and Mortality Weekly Rep.* 631 (2015).

We also urge CMS to expand its efforts to enforce the mental health and SUD parity requirements for state Medicaid plans. We recognize that the agency has already begun to expand its oversight activities by, among other things, requiring states to submit compliance plans outlining efforts to ensure availability of mental health and SUD services without barriers that contravene the parity rule. We urge CMS to continue these enforcement efforts and highlight the importance of continuing gathering information from states that will enable CMS to guarantee compliance. CMS should, moreover, require states to remove barriers that make it more difficult for beneficiaries to access SUD services compared to physical and surgical benefits.

5. CMS should encourage Medicaid coverage of the whole continuum of care for SUD, with particular emphasis on coverage of community-based services.

While access to MAT is essential to reduce the burden of SUD and OUD, coverage of other services is also required to ensure availability of the whole continuum of care for individuals affected by these conditions. Such services include early intervention services, outpatient services, intensive outpatient and partial hospitalization services, and various inpatient services, as well as complementary services such as case management, medication management and monitoring, and recovery services. Medicaid coverage of all of these services is key to effectively address the opioid crisis among low-income individuals as it ensures that beneficiaries receive the services and level of care that is appropriate for their condition considering the beneficiary's skills and needs. CMS should encourage states to cover all services to make available the whole continuum of care under the state's Medicaid plan to the extent possible.

While we support coverage of the full-continuum of care, we are deeply concerned about the mechanisms CMS is using to provide federal financial participation (FFP) for these services. Specifically, authorizing a state to waive the Institution for Mental Diseases (IMD) exclusion, which prohibits federal dollars from being used to pay for services rendered at mental health residential facilities with more than 16 beds, is not legally within the Secretary's authority. Further, all of the above-mentioned services may be provided via a SPA. In fact, under state plan authority, states may provide payment for inpatient and residential services rendered at an acute psychiatric hospital, nursing facility or other facilities with 16 beds or fewer. States may also cover SUD services provided at IMDs via the five-year state plan amendment authorized by the SUPPORT Act, as long as they comply with various requirements designed to protect individuals against institutionalization.

We also oppose CMS incentivizing residential treatment to the detriment of community-based services by continuing to ignore the statutory IMD exclusion using Section 1115 waivers. Regardless of whether individuals with mental health needs or SUD begin their treatment in residential or community-based settings, people need access to a full array of community-based treatment options tailored to their individual needs and CMS should focus its efforts on expanding and incentivizing coverage and federal funding for community-based services.

6. CMS should encourage states to provide SUD services in an integrated way and to improve coordination between Medicaid providers and plans, particularly in states that have carved out behavioral health services from managed care contracts.

Behavioral health services, including SUD services, have historically been provided in silos, separated from the rest of the health care system, and with little to no coordination between providers rendering the services and plans administering them. This is particularly a concern in states that have carved out SUD services from managed care contracts and where coordination between mental health plans and managed care plans is often lacking. We urge CMS, as part of its Action Plan, to encourage or require states to adopt strategies to ensure that SUD services for Medicaid beneficiaries are appropriately integrated and to enable coordination between providers and between plans. This entails taking advantage of the flexibilities afforded by the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. Part 2 to encourage covered entities to share data and treatment information that would ensure that the beneficiary is receiving appropriate care at all times.

Conclusion

We thank you for the opportunity to provide feedback on the development of CMS’s Action Plan to address the opioid epidemic and for your consideration to our comments. We urge CMS to adopt a plan that recognizes the value of Medicaid as a tool to fight the crisis and that encourages states to improve access to the whole continuum of care for SUD prevention and treatment. If you have further questions, please contact Staff Attorney Héctor Hernández-Delgado at hernandez-delgado@healthlaw.

Sincerely,



Elizabeth G. Taylor
Executive Director

