Testimony for the Record
Submitted to the U.S. Senate Finance Subcommittee on Health Care
For the Hearing "Closing Gaps in the Care Continuum: Opportunities to Improve Substance Use Disorder Care in the Federal Health Programs"
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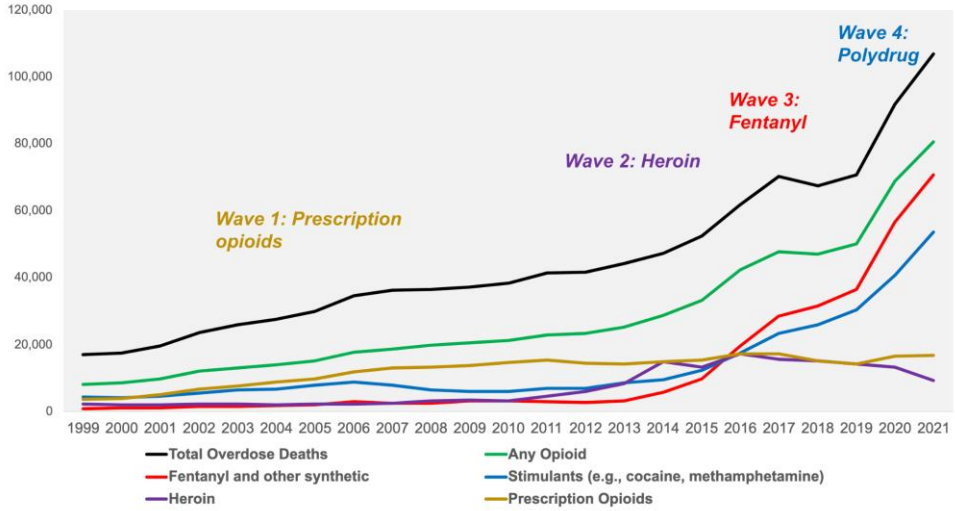
Chairman Cardin, Ranking Member Daines, and members of the Health Care Subcommittee, thank you for inviting me to speak this afternoon. My name is Brendan Saloner and I am a Bloomberg Professor of American Health at Johns Hopkins University. My research focuses on reducing the terrible toll of addiction and overdose in the United States by improving the health and wellbeing of people who use drugs. Additional areas of expertise relevant to today's hearing are the Medicaid program and health insurance design. The views expressed are my own and do not necessarily reflect the views or positions of the Johns Hopkins University or the Johns Hopkins Health System.

Substance Use Disorders and Overdose Are Pervasive and Preventable Harms

The drug overdose crisis is a multigenerational challenge that undermines American life expectancy, economic productivity, and individual potential.[1,2] The most recent data from the Centers for Disease Control and Prevention indicate that 107,941 Americans died of an overdose in 2022 – the highest number ever recorded.[3] Our overdose crisis has proceeded in "waves": in the 1990s prescription opioids were the dominant drug involved in fatal overdose, heroin became the leading opioid in 2013, followed by illicitly manufactured fentanyl in 2016.[4] The nation has now entered a fourth wave characterized by polydrug overdoses that involve opioids in combination with stimulants such as cocaine or methamphetamines.[5] It is important to acknowledge that no single wave of the overdose crisis has completely receded – we are still experiencing the effects of each of the first three waves of the overdose crisis.



Source: Analysis of Centers for Disease Control and Prevention data (https://wonder.cdc.gov/)

Overdose is the most visible harm, but substance use disorders (SUDs) are pervasive – recent data indicate that 49 million Americans meet screening criteria for an alcohol or drug use disorder.[6] Overdose and SUDs affect all segments of American society, but have a disproportionate impact on people in federal health care programs, including lower-income people, people from minoritized communities, and those with disabilities.[7] Moreover, overdose in recent years rose rapidly at the tails of the age distribution – among both adolescents and older adults, groups that are often enrolled in Medicaid, CHIP, and Medicare.[8,9]

Improving access and quality to substance use related health services in federal health care programs could make a major impact on overdose mortality, because we have lifesaving treatments. Unfortunately, only *about one-quarter* of all people who meet screening criteria for SUD have received *any* treatment in the past year, and often treatment is received for periods of time that are too short or they do not receive the best available treatments.[6] For example, patients are often retained in opioid use disorder (OUD) treatment for less than six months.[10] While important progress has been made over the last decade, most people with OUD still do not receive standard of care treatment with medications.[6]

In my testimony today, I will lay out three goals that can guide federal health care programs as they respond to this national challenge.

The goals I describe are interlinked – they focus on practical steps that can be taken in federal health care programs to ensure that all beneficiaries receive evidence-based care in the settings where they need it the most. These goals reflect the perspective that *SUD care should be supported with the same resources, oversight, and standards as any other chronic diseases.* National efforts to reform SUD care are still overcoming a deep-seated legacy of stigma and discrimination. SUD care should be considered part of mainstream health care. *Rising to this challenge means meeting people "where they are at", which requires removing barriers to starting care, and working across disparate systems, payers, and cultures.* Federal legislation can continue to expand the scope of health care to include non-traditional sources of support such as peer recovery workers and engage with other service systems, including social services, housing, child welfare, and the criminal legal system.

<u>Goal 1: Align covered benefits with clinical consensus</u>

Congress should consider legislation that ensures that federal health care programs cover a standard benefit package that aligns with clinical consensus about essential services for SUD. The American Society of Addiction Medicine (ASAM) defines a continuum of care for SUD treatment that matches the setting and modality of services to the individual needs of patients.[11] Federal programs have historically not covered the full continuum of care, or have created restrictions on services that are not aligned with clinical consensus.

It is important to give credit where it is due – there has been tremendous progress over the last decade and many gaps in the continuum of care have been closed through legislation. One example is *coverage for methadone maintenance,* a necessary and lifesaving treatment option for people with opioid use disorder. A decade ago, a dozen state Medicaid programs offered no coverage of methadone maintenance and Medicare excluded methadone maintenance entirely.

The SUPPORT Act closed these important coverage exclusions, so that OUD treatment services, including methadone, provided by federally regulated opioid treatment programs are now covered in Medicare Part B.[13] In addition, with the passage of recent legislation, the SUPPORT Act's temporary requirement that state Medicaid programs cover all medications for the treatment of opioid use disorder, including methadone, along with related counseling services and behavioral therapy, has now been made permanent. Another example is Medicaid coverage of residential addiction treatment programs. The so-called Institutions of Mental Disease (IMD) exclusion in Medicaid has long prevented state programs from covering services in specialty inpatient or residential facilities with over 16 beds that primarily provide SUD care in the absence of special authorities.[12] Recent legislation would make permanent the SUPPORT Act's state plan option to allow states to pay for SUD care in such facilities for up to 30 days per year, per beneficiary.

It is now crucial to build upon expanded coverage options in two concrete ways:

- *Continuing to close gaps in the continuum of care*. In Medicare, there is still a need to add coverage for non-hospital residential treatment,[13] an important aspect of care for many patients with SUD. In Medicaid, coverage of medications for substance use disorder have improved though important gaps remain. For buprenorphine, this means ensuring that state Medicaid programs do not impose arbitrary limits on dosage and duration of treatment.[14] Strengthening and enforcing requirements of federal parity laws can reduce clinically inappropriate limitations. For methadone, likewise, there are state laws that limit the ability of providers to take advantage of new federal flexibilities related to telehealth and extended take-home privileges.[15] Some states even prevent the establishment of new methadone clinics that are urgently needed to increase access.[16]

- *It is critical to ensure that federal health care programs have adequate provider networks in settings that are geographically proximate to beneficiaries*. Patients routinely travel long distances to receive SUD care, which reduces their retention in care.[17] One reason is that managed care plans do not always contract with a sufficient network of providers.[18] Overcoming this problem requires implementing comprehensive network adequacy requirements with regular audits to ensure that contracted providers, especially addiction specialist clinicians, are willing and able to accept new patients. In many cases, network adequacy requirements do exist but are not consistently applied or do not draw on updated network information.[19] Congress can require regular reporting and define standards for network adequacy in federal health care programs. Settings with services that are tailored to special populations are also in very short supply including those accepting adolescents, people with limited English proficiency, complex psychiatric needs, and pregnant people.[20]

Goal 2: Ensure access to care at key touchpoints

The second major goal is to ensure that federal programs are supporting beneficiaries when they need care in moments of crisis. To do so, policy should focus on "touchpoints," points of system contact that identify individuals at high-risk of overdose death and engage them in risk reduction programs (e.g., overdose education and naloxone distribution) and treatment.[21] As an example,

people who experience a nonfatal overdose are dramatically more likely than the general population to die of an overdose in the next year than the general population.[22] However, these individuals routinely fall through the cracks, as there is often a lack of follow-up and engagement with services. Less than one-fifth of overdose survivors receive medication treatment in the months following their overdose.[23–25] Congress should define standards for providers to follow and invest in new entry-points to care that focus on people in crisis, for example:

- *Hospital emergency departments:* in 2019, there were 8 million visits to emergency departments for SUD related causes.[26] Best practices for treating patients in hospitals after opioid overdose is to provide them with prompt access to medications for opioid use disorder and to initiate a warm handoff with continuing care. These models reduce risk of overdose and readmission.[27] However, most US hospitals still lack the capacity to provide treatment with medications. According to legal analysis, hospitals may be violating federal laws such as the Americans with Disabilities Act (ADA) and the Emergency Medical Treatment and Labor Act (EMTALA).[28] It should be a requirement for participation in federal health care programs that hospitals possess the capability to treat opioid use disorder with medications.

- *Residential treatment facilities:* residential treatment facilities provide clinically-managed 24 hours care for people with acute substance use needs, particularly those with complex comorbidities. While such facilities should be among the most carefully regulated, state and federal agencies often provide limited oversight of these programs. At the most egregious level, residential treatment facilities can be involved in deceptive or illegal practices such as patient brokering, often in coordination with unregulated "sober homes" not licensed to provide treatment.[29] More commonly, residential treatment programs cannot deliver the full standard of care to patients. For example, only about one-third of all residential programs in the US can offer OUD treatment with medications,[30] and audit studies find that even programs that can offer such treatment are discouraging patients from receiving them.[31] Federal health care programs have leverage to require residential facilities to meet nationally recognized program standards, including providing access to medications. Medication requirements for residential facilities already exist in state regulations in Louisiana,[32] New York,[33] and California.[34]

- *The criminal legal system:* Release from a jail or prison has long been known to be a period of dramatically higher overdose risk, with mortality risk in the two weeks after release more than twenty-fold the rate of the general population.[35] As was shown in Rhode Island, treating opioid use disorder in carceral facilities can drive down post-release overdose,[36] yet these treatments remain uncommon. For example, in 2019, only one-fifth of jails were able to start people on medication treatment.[37] While progress is being made in some jurisdictions, progress has been slower nationally. The recent Section 1115 waivers to the Medicaid Inmate Exclusion in California and Washington are going to demonstrate the effectiveness of models to cover pre-release services. Under these waivers, states are required to provide access to medications for opioid and alcohol use disorder prior to release.[38] It is imperative that Medicaid and other federal programs use their leverage as payers to ensure that carceral facilities receiving federal funds offer the same standard of care for their patients as exists in community programs after release.

Goal 3: Reward quality care and de-adopt low-value care

Because of the longstanding exclusion of SUD treatment from mainstream health care, SUD treatment is lagging behind in adopting quality measurement and testing new models of care delivery that could deliver quality to beneficiaries and value to taxpayers. It is critical to accelerate efforts to create a market for quality care so that the system is more transparent and easy to navigate. Under the status quo, individuals in crisis must navigate a system that is incredibly opaque and for which there is limited public reporting of quality outcomes.

- *Expand the use of quality measurement:* the National Center for Quality Assurance (NCQA) recently debuted the first Healthcare and Effectiveness Data Information Set (HEDIS) measures for substance use treatment that focus on follow-up care after an acute event (such as a substance use-related hospitalization) and initiation and retention in care.[39] Across payers, we can see that there are major shortfalls in these process-based quality of care measures.[40] These HEDIS measures should become part of routine public reporting for accountability of CHIP, Medicaid managed care, and Medicare Advantage plans. Furthermore, such measures should become integrated with existing value-based payment programs. Federal health care programs already provide targeted payments for managed care plans to manage chronic diseases such as depression and diabetes,[41] Congress should mandate that they follow the same approach for SUD treatment.

- *Support innovative care delivery models:* a proliferation of innovative care delivery models now exist in substance use treatment, including "bridge clinics"[42] (interim care locations that can be accessed on a "walk-in" basis), stabilization centers,[43] mobile treatment units,[44] street outreach teams,[45] and co-located services in primary care and community health centers.[46] A key advantage of these models is they provide timely onramps to care in settings that may be more accessible or person-centered. Bringing these models to scale, however, requires overcoming challenges with staffing and reimbursement. Congress should encourage the Centers for Medicare and Medicaid Services (CMS) to evaluate demonstrations that test the feasibility and cost-effectiveness of new care delivery models, and ensure that rate setting processes adequately adjust to newer modalities of care delivery (such as mobile opioid treatment program services).

- *De-adopt low-value care:* Low-value care is pervasive in the health care system,[47] and unfortunately SUD treatment is no exception. Payers and purchasers need to phase out treatments that do not have demonstrated clinical effectiveness. One potential example is standalone opioid withdrawal management (sometimes called "detoxification") that does not include continuing care in the community,[48] another is urine drug testing that is performed multiple times within the same "window of detection" (the amount of time in which drug metabolites can be detected by a test).[49] A more complete process for grading the evidence and aligning evidence with coverage decisions could be convened by a national expert body in collaboration with the federal government.

Conclusion

In closing, the nation is at a pivotal moment to reverse the course of our overdose and addiction crisis. Federal health care programs are an indispensable part of the solution. When a person in

crisis does not receive prompt care, and when the system is not there to support their continued engagement with quality services, the risk of tragic outcomes is very high. But we have also seen that when doors to effective treatment are open, people can recover, thrive in their own health, fulfill their potential as neighbors, parents, and coworkers, and contribute to our collective success. I urge the committee to support legislation that removes outdated coverage obstacles and gives providers the tools to provide the highest standard of care to people seeking recovery. Thank you for the opportunity to testify and I would be happy to answer any questions you may have.

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