



EXCEPTIONAL CARE. WITHOUT EXCEPTION.

May 15, 2018

The Honorable Greg Walden  
Chairman  
Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Frank Pallone, Jr.  
Ranking Member  
Energy and Commerce Committee  
2322A Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Michael C. Burgess, M.D.  
Chairman  
Subcommittee on Health

The Honorable Gene Green  
Ranking Member  
Subcommittee on Health

Dear Chairman Walden, Chairman Burgess, Ranking Members Pallone and Green,

Thank you for the opportunity to appear before the Subcommittee on Health on April 12, 2018, to testify at the hearing entitled "Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients."

Accompanying this letter are my responses to the additional questions for the record from Chairman Burgess and Ranking Member Pallone. Thank you in advance for your consideration of my comments. As always, if I can be of any additional assistance, please do not hesitate to be in touch.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Botticelli". The signature is stylized with a large, sweeping "M" and a long, horizontal stroke extending to the right.

Michael Botticelli  
Executive Director  
Grayken Center for Addiction at Boston Medical Center



**Answers to Questions for the Record from Michael Botticelli, Executive Director  
Grayken Center for Addiction at Boston Medical Center**

**May 15, 2018**

**U.S. House of Representatives Committee on Energy and Commerce Health Subcommittee Hearing  
*Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients***

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**The Honorable Michael C. Burgess, M.D.**

1. *The National Association of Boards of Pharmacy reports that 39 states already mandate use of PDMPs. What has your experience been in using PDMPs to combat the opioid crisis? What is your sense on how providers and dispensers view the usefulness of PDMPs?*

**Prescription Drug Monitoring Programs (PDMPs) have been highly successful in reducing excessive opioid prescribing and identifying problematic drug interactions, e.g. prescriptions for opioids and benzodiazepines. Robust PDMPs – which have real-time data and high numbers of registrants and users – have been shown to significantly reduce both problematic prescribing and opioid overdose deaths.<sup>1</sup> To enhance the utility of state PDMPs, it is important that federal resources be sufficient to ensure data sharing among states and the interoperability with electronic medical records to minimize the burden on prescribers.**

2. *Numerous studies have found that Medicaid enrollees have excessive burdens of chronic pain and are at a much higher risk of substance use disorders compared to populations with other types of insurance. Similar studies have found that Medicaid enrollees are thus at heightened risk for prescription opioid misuse and were five to six times as likely to die from opioid-related overdose compared to populations with other types of insurance. Because of this, according to the authors of one such study, which I quote: “reducing the number of unsafe prescriptions of opioids in the Medicaid population should be a priority for any drug control policies.” I believe that we have several bills before us today that will help achieve that goal. Our Pharmacy Home Bill, our PDMP Bill, and our DUR bill for example. Do you believe that these policies will help to advance the important goal of reducing the number of opioids in the Medicaid population?*

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<sup>1</sup> Patrick SW, Fry CE, Jones TF, Buntin MB. Implementation Of Prescription Drug Monitoring Programs Associated With Reductions In Opioid-Related Death Rates. *Health Affairs*, 2016; 35(7): 1324-42.

Yes, I believe though with the caveat that efforts to ensure reductions in the number of opioids in the Medicaid population are coupled with increased access to evidence-based non-pharmacologic pain management services as a means to avoid the possible unintended consequence of not appropriately treating members' pain.

3. *The Medicaid HUMAN CAPITAL Act would provide enhanced funding for states to recruit highly-experienced Medicaid directors, Chief Information Officers, and Chief Financial Officers. In Mr. Douglas's testimony, he discusses the importance of strengthening Medicaid's role as a payer in combatting opioid misuse. He notes "Congress should implement policies that support state recruitment and retention of strong Medicaid executive leadership," because as he explains, a stable and strong state leadership will be best equipped to respond to the opioid crisis and further public health crises." In your opinion, is it helpful to improving Medicaid's role in addressing the opioid epidemic and other public health challenges by helping states secure the most talented, innovative, and experienced leadership possible?*

**No comment – I defer to my other esteemed panelists.**

4. *I am interested in the draft that proposes a demonstration project to increase provider capacity in Medicaid for treating substance use disorder. States could apply to use the funds to recruit or train current or new providers. However, I do have several concerns with the idea. Given all the funds that Congress has authorized to support provider capacity such as GME as well as grants from HRSA, SAMSHA, and CDC. Is this idea duplicative? I am also unclear why we would start a new program when those are well established and have staff that understand workforce capacity. Can you comment on that?*

**While a demonstration project to increase provider capacity in Medicaid for treating substance use disorder (SUD) might be duplicative, there are, as it stands, too few providers trained and authorized to treat SUD, especially in Medicaid, so we need to continue aggressive efforts to increase provider capacity in this most critical area. It is worth examining whether existing programs are adequately resourced to achieve these goals.**

#### **The Honorable Frank Pallone, Jr.**

1. *The need for access to opioid use disorder treatment is growing for Medicare beneficiaries. Unfortunately, a number of gaps in coverage exist that limit beneficiaries' options for receiving treatment.*
2. *What are some of the existing opioid use disorder treatment gaps in Medicare and why are these important to resolve?*
3. *We have heard how the best treatment for opioid use disorder includes both medication and behavioral therapies. Medicare covers some, but not all of these necessary treatments, specifically Methadone for maintenance therapy for opioid use disorder is not available for Medicare beneficiaries who require*

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U.S. House Energy & Commerce Committee | 05.15.18

(Combined answers to Medicare questions 1-3)

Many patients are limited as to what medications they can access, if any. An existing opioid use disorder treatment gap of note is Medicare does not cover outpatient Opioid Treatment Programs, although there are bills, including one by Ranking Member Pallone to address this.

4. *Why is it important to include all aspects of opioid use disorder treatment for beneficiaries suffering with substance abuse?*

It is of the utmost importance for Medicaid and Medicare to cover all aspects of opioid use disorder treatment, including all three FDA-approved forms of MAT. As is the case with any disease, clinicians caring for patients with opioid use disorder need as many treatments as possible at their disposal, since based on clinical assessment and patient preference, what is the right course of treatment for one person might not be right for the next one. In addition, a wide variety of therapeutic and recovery services have a role to play in promoting recovery, especially considering the high rates of co-occurring disorders in people with opioid use disorder, e.g. combining pharmacologic treatment with behavioral therapy.

5. *How can we expand the scope of services existing providers offer and increase the overall numbers of providers available to treat substance abuse disorders?*

There exists a huge gap between the number of people with opioid use disorder and the proportion of this population that is prescribed medication. The small percentage of providers that prescribe all three FDA-approved medications could be dramatically increased by requiring all federally-funded substance use disorder treatment programs to provide all three FDA-approved medications, and that they remain consistent with approved best practices going forward. As some states have demonstrated, the use of CMS' 1115 waiver process has allowed states to successfully increase the services that qualify for federal reimbursement. In Massachusetts, for example, Residential Rehabilitation and Recovery Coach services will become Medicaid reimbursable services. This waiver process also allows states to waive IMD requirements by demonstrating a continuum of services. This is a much more reasoned and prudent approach than just eliminating the IMD exclusion alone.

6. *What areas would you recommend CMS focus on to improve opioid use disorder treatment?*

Please refer to my answers to previous questions and recommendations offered in my testimony,

7. *How can Medicare assist in increasing the number of MAT prescribers available to treat opioid use disorders?*

Both Medicare and Medicaid should evaluate their reimbursement structures for ways to remove barriers and provide greater incentives to increase the number of MAT prescribers.