Testimony of Michael Botticelli, Executive Director
Grayken Center for Addiction at Boston Medical Center

April 12, 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

---

Thank you Chairman Burgess, Ranking Member Green, Chairman Walden, Ranking Member Pallone, and Members of the Health Subcommittee, for the opportunity to speak today about how we can make progress against the opioid epidemic and particularly the roles of Medicaid and Medicare in combating the opioid crisis.

My name is Michael Botticelli. I am the Executive Director of the Grayken Center for Addiction at Boston Medical Center. Boston Medical Center is the largest safety-net provider in New England, with approximately 42% of our patients insured through Medicaid, and another 27% through Medicare.

For decades, Boston Medical Center, or BMC, has been a leader in treating substance use disorders. Many BMC programs have been replicated across Massachusetts and nationally. The Grayken Center for Addiction at BMC, launched last year with a $25 million gift from the Grayken family, encompasses over eighteen clinical programs for substance use disorders and serves as the umbrella for all of BMC's work in addiction including treatment, training, research, and prevention.

I offer my perspective as the Executive Director of the Grayken Center, as well the insight gained from my over 25-year career in addiction services, formerly having served as the Director of the White House Office of National Drug Control Policy and as Director of the Massachusetts Bureau of Substance Addiction Services. My perspective is also as a person in recovery.

The experience at BMC and in Massachusetts highlight the critical role that Medicaid plays in addressing the opioid epidemic. This cannot be overstated. The vast majority of BMC patients receiving treatment for opioid addiction have Medicaid, which in Massachusetts is widely available to low-income individuals and families and covers a comprehensive set of benefits that allow our providers at BMC to serve our patients most appropriately.

Massachusetts' Medicaid program, known as MassHealth, covers all three FDA-approved medications for opioid use disorder, includes naloxone on its formulary, and covers residential treatment and recovery coach services, all benefits which are not available in many other state Medicaid programs. Sadly, in America today, access to substance use disorder treatment is very much determined by where a person lives.

Among the many bills under consideration by your committee are numerous opportunities for Medicaid to play a more substantial role in addressing the opioid crisis. I would like to briefly discuss a few of the areas that I think are most pressing for action:

- All FDA-approved medications for opioid use disorder should be available to patients. The evidence for medication for addiction treatment (MAT) is unequivocal – patients with medication experience significantly improved rates of recovery. Yet, many settings do not make some or all MAT available because of misunderstanding or lack of training. Only one in five people with opioid

use disorder receive medication, while the percentage for youth is even less.[1] In the words of Secretary of Health and Human Services Alex Azar: "Failing to offer MAT is like trying to treat an infection without antibiotics."[2] And, like any disease, clinicians need as many treatments as possible, since what is right for one person might not be right for the next one. However, many patients are limited as to what medications they can access, if any. Medicare, for example, does not cover outpatient Opioid Treatment Programs, although there are bills, including one by Ranking Member Pallone to address this. Any federally-funded substance use disorder treatment program, and any program that bills Medicaid or Medicare should be required to provide medications consistent with approved best practices.

- Medicaid and Medicare should make naloxone universally available without a co-pay. In 2017, Massachusetts for the first time saw an 8.3% drop in annual opioid overdose deaths, the first year of decrease since 2010. But, at the same time, the number of non-fatal opioid overdoses went up.[3] What that suggests is that broad availability of naloxone in Massachusetts is keeping more people alive while the epidemic is continuing to grow.

- Overdose data in Massachusetts also shows that individuals recently released from incarceration overdose at 120 times the rate of the general public, most often within the first two weeks

[1] Wu L, Zhu H, Swartz MS. Treatment utilization among persons with opioid use disorder in the United States. *Drug and Alcohol Dependence*, 2016; 169: 117-217.
[2] U.S. Department of Health and Human Services Secretary Alex Azar. Plenary Address to National Governors Association. February 24, 2018.
[3] Massachusetts Department of Public Health. "Data Brief: Opioid-Related Overdose Deaths Among Massachusetts Residents." February 2018.

following release.[4] This devastating trend emphasizes the need to focus on transitions to care for patients leaving incarceration, as well as treatment during incarceration, as several bills under review by this committee have proposed.

- Despite modest decreases in prescribing in the United States over the past few years, prescribing of opioids is still a major driver of this epidemic. Medicaid and Medicare should ensure that prescribers have continuing education around safe prescribing, as well as that they register for and use state-based Prescription Drug Monitoring Databases, in order to more appropriately treat pain and diligently track prescribing patterns to limit forum shopping for opioids.

- To complement the largely successful efforts to reduce opioid prescribing, we need to ensure that patients have access to non-pharmacologic pain management practices, such as acupuncture, physical therapy and cognitive behavioral therapy. Unfortunately, only about a half of state Medicaid programs specifically support or require these services.[5]

- Access to services continues to be a barrier in many parts of the country. A study by Emory University showed that 40% of counties in the United States did not have an outpatient treatment program that accepted Medicaid.[6] CMS can and should use its network adequacy standards for both managed Medicaid and Medicare Advantage plans to ensure sufficient access to treatment services. While provider reimbursement rates through Medicaid are set by states, and each state

[4] Massachusetts Department of Public Health. "An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015)." August 2017.
[5] Dorr H and Townley C. Chronic Pain Management Therapies in Medicaid: Policy Considerations for Non-Pharmacological Alternatives to Opioids. National Academy for State Health Policy. August 2016.
[6] Cummings JR, Wen H, Ko M. Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States. *JAMA Psychiatry*, 2014; 71(2):190-196.

has its own budget constraints, CMS could do more to illuminate and ameliorate the issue of low provider enrollment in Medicaid, which contributes to a lack of access to SUD and behavioral health treatment in many parts of the country.

BMC has many treatment programs that have become national models. The foundation for all of these programs is the absence of stigma. Without exception, patients who were aided to recovery at BMC credit the lack of judgement they felt in our programs. Medicaid and Medicare can and should do more to get evidence-based addiction treatment to patients. We can all do more to see that people with substance use disorders are welcomed as patients.

Addiction is a disease, and recovery should be the expected outcome of that disease.

Thank you for your time. I look forward to your questions.