NATIONAL HEALTH CARE for the HOMELESS COUNCIL

February 14, 2018

The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
United States Senate

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
United States Senate

Dear Chairman Hatch and Ranking Member Wyden:

That National Health Care for the Homeless Council is responding to your request for information, dated February 2, 2018, seeking policy recommendations for addressing the opioid crisis. Addiction can cause and prolong homelessness and homelessness complicates one's ability to engage in treatment. A study in Boston found that drug overdoses accounted for 17% of deaths amongst people experiencing homelessness, with opioids responsible for a majority of these deaths. The Health Care for the Homeless (HCH) program is funded through the Health Resources and Services Administration (HRSA). Unlike traditional health centers, HCH programs are required to provide outreach and substance abuse services. Given this requirement, and the needs of the population we serve, HCH programs typically have integrated behavioral health and primary care services and care coordination across multiple venues. As such, the HCH community is well positioned to address the barriers to care and areas for improvement when it comes to combatting the opioid epidemic, particularly among low-income individuals.

We are heartened by this request and strongly support the implementation of best practices and changes to the current system. However, please note that the pivotal solution to combatting the opioid crisis is the **expansion of health insurance coverage**. There are 29 million people in the United States without health insurance and comprehensive affordable health insurance is critical to accessing addiction treatment and addressing health needs. **Medicaid must be expanded, not curtailed,** in order to effectively address the health care needs of low-income vulnerable people—particularly those with opioid addiction.

Below are responses to the questions in your request for information:

Question 1: How can Medicare and Medicaid payment incentives be used to promote evidence based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?

By enforcing parity laws. Substance abuse treatment and other behavioral health services should be as easy to access as primary care services. Parity laws are in place to ensure insurance plans treat these services equally, and should be enforced. Health insurance practices that require prior authorizations for opioid treatment should be scrutinized, especially when they create barriers to behavioral health care that do not exist for primary care. Just as there are no prior authorizations required for opioid drugs prescribed for pain management, there should be no prior authorizations required for Medication-Assisted Treatment. Addiction is a time-sensitive condition to treat, and presenting for treatment is a big step for patients; even a delay of one day can be the difference in someone getting treatment or not.

Question 2: What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?

The lack of support services: A broad range of supports are needed to make access to care, particularly access to consistent non-pharmaceutical therapies possible. Transportation, food, housing, and child care are critical

components to successful treatment, yet are frequently inaccessible to those we serve. Our patients have a very difficult time coming to us for care if they are living on the street, hungry, if they have no way to get to us, and/or no one they can trust with their children.

Question 4: Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?

Yes, such as removing the cap on the number of patients a physician can treat with buprenorphine. Existing limits are arbitrary and create barriers to accessing treatment. While put in place to mitigate diversion, limits may inadvertently aid diversion by limiting the supply of for Medication-Assisted Treatment, leading to individuals pursuing self-treatment by purchasing diverted drugs. Ironically, there are no limits to the number of patients a physician can prescribe other opioid drugs that present a much greater risk of causing addiction, overdose, and death (e.g., Methadone, Oxycodone, Hydrocodone, and Fentanyl). Removing the caps will allow providers to determine the number of patients they are able to treat based on the capacity of their practice and other factors, thereby increasing access to treatment.

Question 5: How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

By requiring training to prescribe all opioids, not just buprenorphine. Specialized training is required to prescribe buprenorphine, but no other drug (opioid or otherwise) requires this as a condition of practice. Given the lower risks associated with diversion of buprenorphine, and the elevated risk associated with many opiates that can be prescribed with few restrictions, training should be extended to the prescribing of any opioid and focus on administering and monitoring prescriptions and understanding the nature of addiction. In addition, prescribers should have greater access to technical assistance and resources to develop plans to identify and avoid diversion.

Question 7: What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

The implementation of harm reduction programs. Low-barrier treatment options that do not impose rigid requirements are critically needed to address the significant needs of a vulnerable population. Barriers include programs that require copays, adherence to numerous medical and therapy appointments, and requirements for sobriety/abstinence, etc. Piloting new programs such as safe injection sites and expanding existing needle exchange programs are also critical steps to promoting public health and preventing overdose deaths. Federal support of these practices will increase the nation's ability to combat this crisis.

Question 8: What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUH on children and families?

Reducing stigma and treating addiction as a disease. The main barrier to any type of treatment for persons experiencing homelessness is a lack of stable housing. But, drug screens are often required when accessing housing, and employers often require drug screens for employment. Landlords and employers need to accept buprenorphine prescribed as part of a for Medication-Assisted Treatment plan as a medical treatment process, and not have it count negatively against a person by including it as a prohibited substance. Addiction needs to be seen as a disease and not a moral failing.

Thank you for the opportunity to comment on this vital issue. Should you wish to discuss further how the opioid crisis impacts people experiencing homelessness and the providers who treat them, please contact Barbara DiPietro, Ph.D., Senior Director of Policy, at 443-703-1346 or at bdipietro@nhchc.org.

Sincerely,

G. Robert Watts
Chief Executive Officer
National Health Care for the Homeless Council