October 11, 2019

Submitted via email to PainandSUDTreatment@cms.hhs.gov
Centers for Medicare and Medicaid Services

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

Dear colleagues,

We are submitting public comment on behalf of the Fenway Institute at Fenway Health, a federally qualified health center in Boston, Massachusetts that serves 32,000 patients each year, including about 700 patients with opioid use disorder (OUD). Fenway Health provides a Medication-Assisted Treatment (MAT) program for patients with OUD. We would like to provide feedback on the development of the CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment.

In order to enhance access to appropriate care for people with OUD, it is important for CMS to consider vulnerable populations that are disproportionately burdened with OUD. Research has shown that LGBT people are at elevated risk for opioid use and misuse. For example, an analysis of aggregated data of 126,463 adults (including 8,241 LGB adults) from the 2015-2017 National Survey of Drug Use and Health found that lifetime pain reliever misuse rates were elevated for LGB adults compared to their heterosexual counterparts.[1] LGB women and gay men had 1.4-2.4 times the odds of past-year opioid misuse, bisexual men had elevated rates of lifetime heroin use, and bisexual women had 2.5 times the odds of OUD compared to their heterosexual counterparts.[2] Research on opioid use among transgender individuals is more limited. One study using 2013-2015 California Healthy Kids Survey data found that transgender middle school and high school students were more than twice as likely to report use of prescription pain medication compared to their cisgender peers.[3] Additionally, transgender Medicare beneficiaries have increased prevalence of chronic pain compared to cisgender Medicare beneficiaries,[4] and mismanagement of chronic pain with opioids can lead to OUD. Minority stress and anti-LGBT stigma and discrimination are also contributing factors to higher prevalence of substance use and substance use disorders among LGBT people.

We encourage CMS to specifically address special populations, including LGBT people, in its Action Plan. In order to enhance access to appropriate care for LGBT people with OUD, it is important to have staff trained in LGBT cultural competency. Anti-LGBT discrimination in health care can act as a barrier to seeking necessary care. Anti-LGBT stigma can compound with stigma surrounding substance use, making it even more critical to have training in cultural competency.

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[1] Schuler M, Dick A, Stein B. (2019). "Sexual minority disparities in opioid misuse, perceived heroin risk, and heroin access among a national sample of US adults." *Drug and Alcohol Dependence.* 201, 78-84.
[2] *Ibid.*
[3] De Pedro KT, Gilreath TD, Jackson C, Esqueda MC. (2017). "Substance use among transgender students in California public middle and high schools." *J School Health.* 87(5):303–309.
[4] Dragon CN, Guerino P, Ewald E, Laffan AM. (2017). "Transgender Medicare beneficiaries and chronic conditions: Exploring fee-for-service claims data." *LGBT Health*. 4(6):404–411.

LGBT people with OUD may benefit most from MAT incorporating best practices for providing trauma-informed care and cognitive-behavioral therapy interventions adapted to work within a minority stress framework.[5] Fenway Health could serve as a model LGBT-focused integrated program for treating OUD. We use a two pronged approach to treating OUD. The first prong consists of trauma-informed individual and group behavioral health care rooted in a minority stress framework, and the second prong is MAT program in our primary care department, which follows a harm reduction model.[6]

In terms of important payment and funding mechanisms to expand access to care for OUD, research has shown that Medicaid expansion has been critical for expanding access to MAT. In a study using Medicaid enrollment and reimbursement data from 2011-2016 in all 50 states, researchers found that in expansion states, MAT prescribing increased by more than 200% after states expanded eligibility while increasing by less than 50% in non-expansion states.[7] There was no statistical difference in rates of opioid prescription between expansion and non-expansion states.[8]

Some states seek Medicaid Section 1115 waivers to test effects of changes in coverage and new innovative care delivery models. States have used Medicaid Section 1115 waivers to fund expanded community-based benefits and services, including housing and employment supports and peer mentoring groups, for people with substance use disorders.[9] These community-based support services are critical for ensuring people with OUD are able to access and adhere to care.

Based on our experience in providing MAT, behavioral, and primary health care to patients with OUD, we have several general recommendations regarding policies and payment mechanisms that CMS should consider in order to improve access to care for all people with OUD:

- Enact payment and coverage policies that would increase access to Naloxone for preventing deaths from opioid overdoses.
- Ensure that opioid prescribing is more closely linked with counseling and screening for OUD risk, controlled substance agreements, and behavioral health-focused interventions for high-risk screeners. Provide coverage/payment that allows patients at particularly high risk the ability to access a wide range of behavioral health resources quickly and seamlessly.
- Remove all prior authorization requirements for buprenorphine-based formulations, which would allow for patients and prescribers to have a more comprehensive conversation about all available options. This would have the most significant impact in the immediate future on patient access to Sublocade (monthly buprenorphine depot injection), which has remained a challenge to access due to current payment/coverage

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[5] Girouard M, Goldhammer H, Keuroghlian A. (2019). "Understanding and treating opioid use disorders in lesbian, gay, bisexual, transgender, and queer populations." *Substance Abuse*.
[6] *Ibid*.
[7] Sharp A, Jones A, Sherwood J, Kutsa O, Honermann B, Millett G. (2018). "Impact of Medicaid Expansion on Access to Opioid Analgesic Medications and Medication-Assisted Treatment." *Am J Public Health*. 108(5): 642-648.
[8] *Ibid.*
[9] Orgera K and Tolbert J. (2019). "The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment." Issue Brief. Kaiser Family Foundation. Available online at: https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/

policies. In addition, the current limitations on accessing any formulations other than the most commonly used option (Suboxone film) has impeded access to treatment for patients who have had negative experiences and/or outcomes previously with Suboxone. Even if they are amenable to alternative formulations, prior authorization requirements create unnecessary obstacles that can block patients from accessing those alternatives.

- Remove all requirements to use specialty pharmacies for any MAT medications—this has primarily been a barrier to accessing treatment that includes injectable MAT (Vivitrol and Sublocade). Current payment/coverage policies requiring the use of specific specialty pharmacies have impeded access to these treatment options. Allowing local pharmacies to stock and dispense all MAT medications would provide increased access to patients, especially those at highest risk who would more likely face negative outcomes or adverse events if there were any delays in accessing treatment.
- Provide a structure that allows for urgent/same-day access to treatment regardless of patient's insurance status upon presenting in any clinical setting—this should include full coverage of appointments, labs, medications, and other costs associated with treatment initiation. The current policies do allow for partial coverage to be put into place somewhat rapidly, but can be hindered due to limited same-day availability of financial assistance staff that would be able to link patients to coverage.
- Although current policies do allow for coverage to be retroactively applied in certain cases, this is limited to a window period of 10 days. Extending this window period would allow for additional flexibility with enrolling patients into coverage, and would ensure adequate reimbursement for patients who were unable to return within 10 days following their initial appointment.
- Even when coverage can be urgently coordinated and/or retroactively applied, coverage does not apply or extend to prescription benefits, which can sometimes take up to 2-3 days to become active. This has often been a significant impediment to initiating treatment for patients, and access would be greatly improved if prescription benefits could be activated concurrently with medical benefits.

Thank you for the opportunity to provide feedback on the development of the CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment.

Sincerely,

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