

**United States House of Representatives  
Committee on Ways and Means**

Hearing on  
“Substance Use, Suicide Risk, and the American Health System”

March 2, 2022

Testimony of Edwin C Chapman, MD

Edwin C Chapman, MD PC

Private Practice

1647 Benning Road, NE Suite 200

Washington, DC 20002

## **Introduction**

Chairman Neal, Ranking Member Brady, and Committee

Thank you for allowing me to participate in today's hearing.

My name is Dr. Edwin C Chapman, Sr. For the past 42 years I have practiced internal medicine just two miles from our U.S. Capitol Building. In 2000 I began treating patients suffering from opioid use disorder as the medical director of 1 of the 3 methadone clinics currently operating in the District of Columbia. It was there that I was introduced to the complex challenges faced by individuals and families confronting many issues including access to mental health and substance use disorder services, housing discrimination, employment difficulties, criminal legal interference with the delivery of their medical care, as well as multiple chronic physical health problems such as HIV/AIDS and hepatitis C. This unique, urban, disproportionately African American population generally began using opioids in the form of heroin, often having been introduced to it decades ago. As an internist, I was most struck by the needed services that these patients were NOT receiving including psychiatric and psychological screenings, housing vouchers, and routine primary care and preventive health screenings.

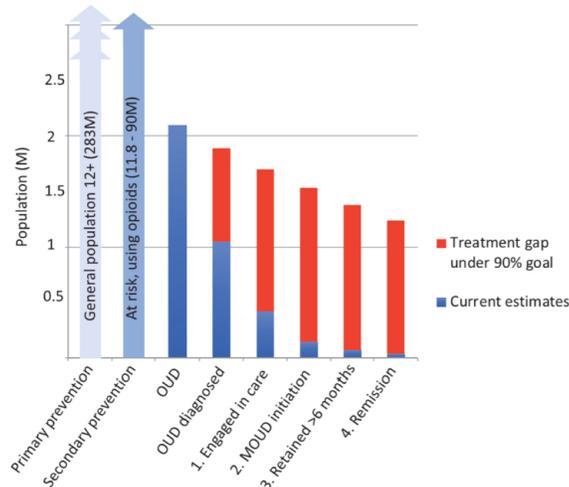
## **The Chapman/Howard University "Urban Health Initiative" Model**

In 2002 I became a member of the American Society of Addiction Medicine, also known as ASAM and currently participate as a Fellow. When buprenorphine, a partial agonist, became available for office-based treatment of opioid use disorder in 2002, I was one of the early adherents in DC although I did not actually use this medication until 2005 under a pilot demonstration project treating people reentering society from incarceration and who remained under the supervision of the Superior Court. That successful project prompted my return to Howard University partnering with the then chairman of psychiatry, Dr William Lawson, in exploring ways to integrate opioid use disorder treatment, mental health services, and primary care in a non-hospital, non-clinic, private practice setting. It was at this point that my office transitioned to using electronic records and introduced telehealth with one-stop connection to a suite of specialty services. The efficacy and efficiency of our prototype model came to full bloom in 2020 when telehealth, because of COVID, suddenly became a necessity rather than a mere convenience or abstraction.

Since 2005, we have treated over 1100 patients with office-based buprenorphine for opioid use disorder and currently serve 225 patients ranging from age 27 to 79, whose average age in 2015 was 52 years and currently increased to 60, with 50% testing positive for hepatitis C and 10-12% HIV positive.

## The Opioid Use Disorder/Infectious Disease Treatment Gap: As a National Security Issue

In January 2019 I was asked to serve on a 10 member committee for the **National Academies of Sciences Engineering and Medicine** “*Opportunities to Improve Opioid Use Disorder and Infectious Disease Services.*” The cascading Figure 2-4 below illustrates the challenges in opioid use disorder diagnosis, treatment, and retention in care.



**FIGURE 2-4** OUD Care Cascade: A proposed OUD Care Cascade, wherein each stage along the x-axis represents a point of intervention to reduce OUD prevalence and increase care.  
 SOURCE: Williams et al., 2019. Reprinted by permission of the publisher (Taylor & Francis Ltd., <http://www.tandfonline.com>).



**FIGURE 2-3** HIV care continuum.  
 SOURCE: HHS, 2016. Used with permission from HIV.gov.

Secondly, Figure 2-3 above similarly illustrates the cascading steps in HIV diagnosis, treatment and retention in care which, when dually diagnosed with opioid use disorder, becomes inextricably dependent upon adequate addiction treatment in order to maintain suppression of viral loads and reduced transmissibility to others.

**Barriers to Care: National Academies of Sciences Engineering and Medicine (NASEM) Listing for OUD and Infectious Diseases, January 23, 2020**

**BOX S-2**

**Barriers to Integration of Opioid Use Disorder and Infectious Disease Services**

**Prior Authorization Policies:** State-level policies often require providers to obtain permission from insurers to prescribe buprenorphine (a Food and Drug Administration [FDA]-approved medication for opioid use disorder). Prior authorization prevents the timely, effective delivery of evidence-based care for opioid use disorder, thereby increasing the risk of infectious disease through continued drug use.

**Drug Addiction Treatment Act (DATA) Waiver Requirement:** Providers are required to apply for the ability to prescribe buprenorphine under the Drug Addiction Treatment Act (DATA) of 2000 (which amended the Controlled Substances Act) and also undergo mandatory training on prescribing practices. Once the DATA waiver is received, providers are limited to a certain number of patients they can treat with buprenorphine. This requirement decreases access to effective medications for opioid use disorder and increases the risk for infectious disease.

**Lack of Data Integration and Sharing:** Due to infrastructural difficulties and federal policies, medical care providers—including infectious disease providers—may not be able to access

patients' information surrounding substance use and treatment, thereby inhibiting comprehensive care plans.

**Inadequate Workforce and Training:** There are several barriers to integration from a workforce perspective, including the geographic distribution and inadequate training of providers who can treat patients with opioid use disorder and infectious disease and restrictions about which providers can deliver certain kinds of care in certain settings.

**Stigma:** Self-stigma and societal stigma surrounding both opioid use disorder and infectious disease may prevent patients from seeking or accessing care, and provider stigma may inhibit a productive patient-provider relationship.

**Payment and Financing Limitations:** Services that are helpful to patients seeking integrated care for opioid use disorder and infectious disease (e.g., harm-reduction services, case management, telemedicine, and peer-recovery counselors) are difficult to obtain or sustain financially.

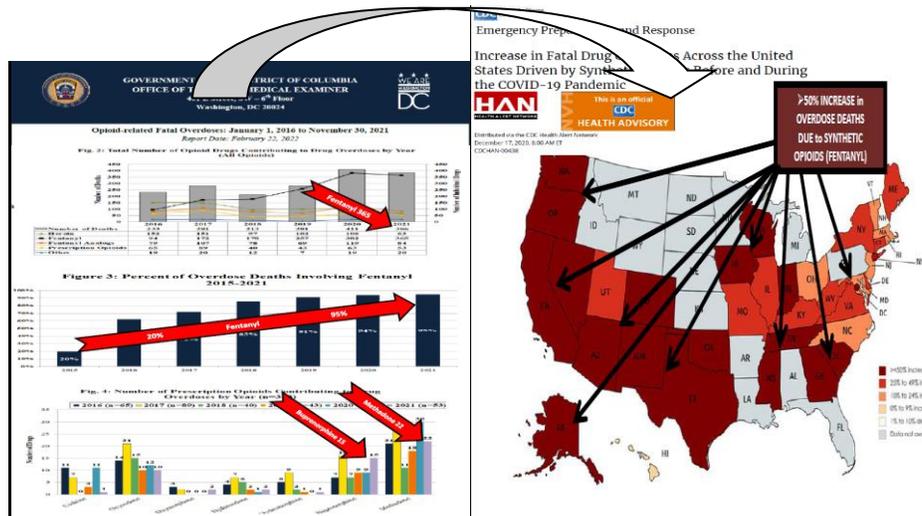
**Same-Day Billing Restrictions:** Some states do not allow providers to bill for a physical and a behavioral health visit in the same day, thereby requiring patients to return for care another day or forcing programs to provide care without the opportunity for reimbursement.

**Limits on Harm-Reduction Services:** Harm-reduction services serve as an entry point for further medical care, reduce the risk of infectious disease outbreaks, and allow for a culture of patient-centered care. Limiting these services, on the other hand, is a barrier to integrating opioid use disorder and infectious disease prevention and treatment.

**Disconnect Between the Health and Criminal Justice Systems:** Care for infectious diseases and opioid use disorder in criminal justice settings is fragmented and inconsistent; the process of maintaining coordinated care while patients enter and exit the criminal justice system is inadequate.

## Assessment

**Stigma** remains a major barrier to care and takes many forms when treating opioid use disorder and/or related infections, and that stigma permeates throughout many commonplace debates and distinctions, such as : (1) addiction as moral problem vs. medical disease, (2) prescribed opioids from the doctor’s office vs. opioids initiated through street access, (3) drug free or antagonist treatment only vs. partial/full agonist medication for opioid use disorder, (4) urban/Black with criminal legal involvement vs. suburban/rural/white with medical treatment, and (5) methadone preferred for poor/Medicaid/Black patients vs. buprenorphine preferred for cash/commercial payers/white patients. Stigma even remains highly prevalent within the medical professional community, community at large, government, as well as payers. Payers in particular, through their use of prior authorizations (PAs) or other utilization management techniques for buprenorphine for opioid use disorder, increase the level of suspicion/stigma related to medications for opioid use disorder (MOUD)/buprenorphine - with prior authorizations often listed as a significant barrier to care by the American Medical Association, American Society of Addiction Medicine, as well as NASEM. The DEA and insurance companies frequently invoke the argument that stringent prior authorizations are needed as a tool to prevent and reduce diversion of MOUD with little reference to safety profiles or actual overdose related death statistics. Multiple studies and evaluations have shown that buprenorphine is a safe, relatively weak opioid with a very high affinity for the opioid mu receptor site and the least likely opioid to be diverted for abuse and, almost always when done so, only to reduce withdrawal symptoms.



**Washington, DC's rapid transition from no fentanyl in 2014 to 20% fentanyl in 2015 to 95% fentanyl in 2021 (83 → 411 deaths = 500% increase) is the unenviable "Canary-in the Mine" for the rest of the country to follow**

**Prior authorizations** (PA) and other types of utilization management techniques are often used by insurance payers as a burdensome cost control mechanism designed to discourage the use of certain medications. They also represent an unnecessary administrative burden that contributes to provider administrative costs and failure to treat. The illustration below is an example of a novel 6 page PA form with no purpose other than to prevent timely treatment with this buprenorphine medication.



**It is far easier to buy fentanyl outside of my office just 2 miles from the U.S. Capital than to get a legitimate buprenorphine prescription.**

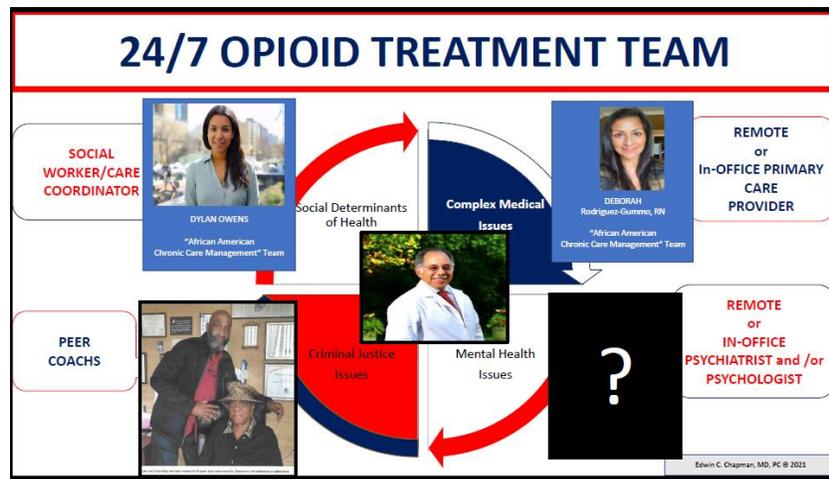
Of the 7 remaining Barriers, 4 are self-explanatory (**#2 - Drug Addiction Treatment Act (DATA) Waiver Requirement**, **#3 - Lack of Data Integration and Sharing**, **#8 Limitations on Harm Reduction**, and **#9 – Disconnect Between the Health and Criminal Justice Systems**). I would refer you to previous testimonies and a wealth of related resources and detailed policy information by experts like the **Georgetown University Law School “Addictions Public Policy Program”** at the **O’Neill Institute**.

Helpful, pending legislative solutions to **#(4) Inadequate Workforce and Training**, include passage of the **H.R. 3441 – Substance Use Disorder Workforce Act**, which would provide an additional 1,000 Medicare graduate medical education (GME) slots to qualifying hospitals that have established, or will establish approved residency programs in addiction medicine, addiction psychiatry, pain medicine, and corresponding prerequisite programs, and **H.R. 2067 – Medication Access and Training Expansion (MATE) Act of 2021**, which would help ensure more

controlled medication prescribers know how to identify, treat, and manage patients with substance use disorder (SUD) and authorize additional resources for health professional schools and residency programs to develop comprehensive SUD curricula.

In addition, passage of **new** legislation that would promote wider payer use of **bundled payments** for the reimbursement of comprehensive addiction services is a solution to barriers **including: #4 Inadequate Workforce and Training , #(6) Payment and Financing Limitations , and #(7) Overcoming Barriers to Same Day Billing Restrictions.** Further, passage of critical provisions that were included in Build Back Better legislative text would help with #(6) Payment and Financing Legislation, such as improving Medicaid /CHIP children and postpartum women; enhancing Marketplace cost-sharing assistance to certain individuals who do not qualify for government sponsored insurance; expanding health insurance premium tax credits for certain populations with low -income; increasing the Medicaid expansion Federal Medical Assistance Percentage; and providing funds to help states establish a state reinsurance program or provide financial assistance to reduce out-of-pocket costs.

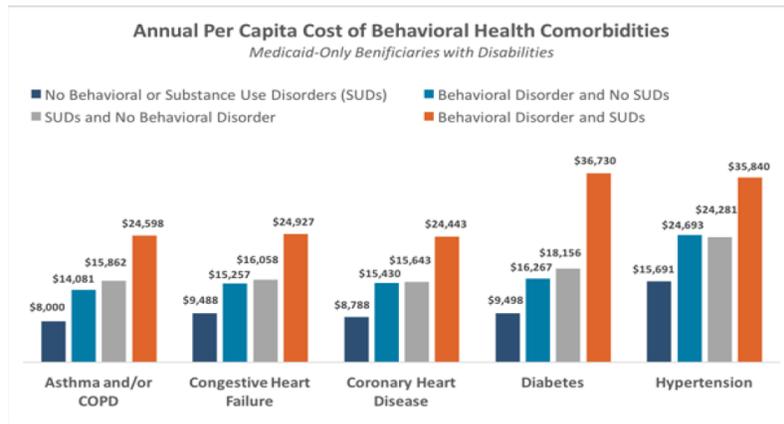
In contrast to the aforementioned bundled payments, the current fee-for-service Evaluation and Management (E&M) payment system under CMMS creates several obstacles for treating complex, costly patients with mental health challenges + substance use disorder + high risk of burden with infectious diseases + chronic medical diseases + challenges related to the social determinants of health (SDoH). There are **NO** consistent payment points for needed companion provider services such as **peer support counselors** and **social workers**, which represents an immediate impediment to comprehensive, value-based care.



**One-Stop private practice treatment model using tele-health integrating substance use disorder + mental health + primary care + social services.**

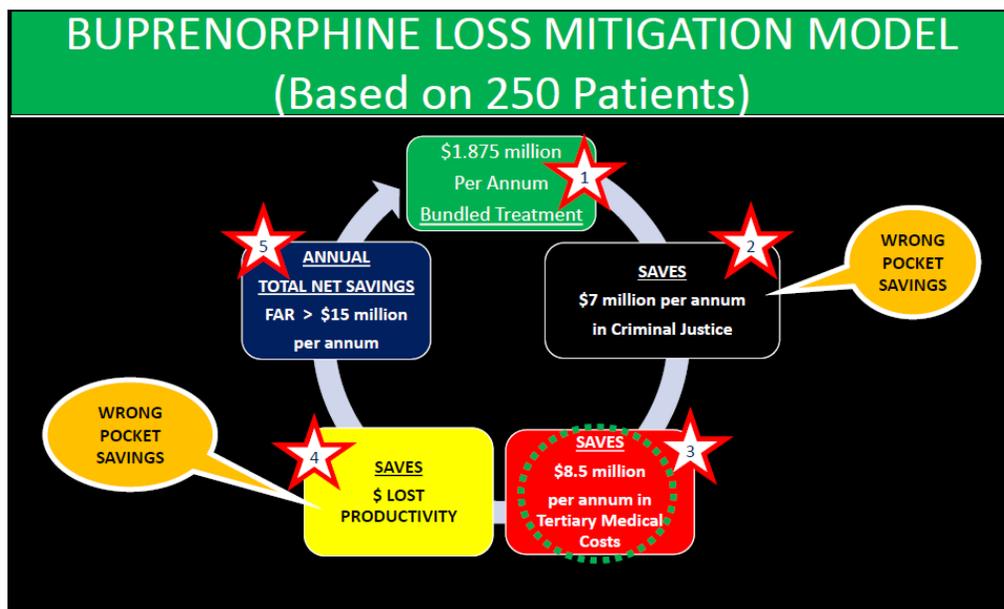
Additionally, failure to pay for multiple, same day services undermine the goals of value based treatment and the objective of saving money through reduced tertiary medical costs (e.g., decreased overdoses, ED visits, hospitalizations, infectious disease). **Estimated costs of non-treatment of opioid use disorder is \$42,000 while treatment with buprenorphine is estimated at only \$7,500 for a net savings of \$34,500.**

**Patients suffering from both a mental health and a substance use disorder cost 4 x more than the average**



Therefore, a monthly, bundled, capitated, direct payment to qualified MOUD providers could streamline accounting and result in enormous medical and non-medical savings to tax payers.

**VALUE BASED CARE = reduced criminal + reduced social service costs (“wrong pocket savings”) in addition to savings from tertiary medical services.**



## Conclusion

Today we are faced with a plethora of corporate challenges related to the burgeoning overdose death rates including (1) Inflated pharmaceutical costs for buprenorphine products and naloxone, (2) provider shortages because of the rapidly, outpaced need to treat addiction, (3) patient, community, provider, and government ambivalence due to stigma and misinformation related to MOUD, and (4) an antiquated, counterproductive payment system for Medicare, Medicaid and private payers with many pockets of patients left untreated due to lack of insurance. Taken together, these issues paint an uninspiring picture with resultant insurance pushback through onerous prior authorizations, artificial and unscientific treatment dosing caps (buprenorphine 16-24 mgs), provider harassment by audits rather than incentive payments to providers and shared savings to taxpayers.

We know after years of failed efforts that punitive measures like incarceration and supply side interdiction have not changed the overdose trajectory in America. We now know that treatment in the form of MOUD is the “gold standard of care” for opioid use disorder. We must therefore, immediately make access to that care ubiquitous and available to everyone who needs it regardless of ability to pay, geographical location, or station in life: Illicit drug suppliers and people suffering from OUD will always find one another as long as we fail to make access to treatment easier than access to illicit markets.

To that end, I also strongly suggest that Congress consider even more aggressive and innovative solutions, such as new legislation that would create a “Marshall” style treatment plan that would provide direct federal payments to providers of any form of MOUD to people who do not have insurance coverage, using a national network of experienced addiction treatment professionals and the **ASAM-AMA Patient Centered Opioid Treatment (P-COAT)** payment model. Patients who do have insurance would continue regular care under their current plan, improved by measures that you can take to eliminate the barriers described herein.