August 21, 2017

Governor Chris Christie, Chair
President's Commission on Combating Drug Addiction and the Opioid Crisis
The Office of National Drug Control Policy
750 17th St, NW
Washington, DC 20006

Submitted electronically: commission@ondcp.eop.gov

RE: Draft Interim Report

Dear Governor Christie:

The National Viral Hepatitis Roundtable (NVHR) is a broad coalition of 500 organizations working to end the hepatitis B and C epidemics in the United States. On behalf of the nearly 5 million people living with hepatitis B or C, we appreciate this opportunity to provide comments to the President's Commission on Combating Drug Addiction and the Opioid Crisis ("the Commission") on its Draft Interim Report.

One devastating public health consequence of the opioid crisis in the United States is the growing number of people infected with hepatitis B virus (HBV) and hepatitis C virus (HCV). HCV is the deadliest infectious disease in America, killing nearly 20,000 people in 2014 alone,[1] and injection drug use is the cause of most new infections.[2] From 2010 to 2015, the number of new HCV infections jumped by 294 percent, with particularly sharp increases among states hardest hit by the opioid crisis.[3] Reported cases of HBV, which can also be transmitted via injection drug use, increased 20.7 percent in 2015.[4] Because of the direct link between injectable opioid use and HBV/HCV, any initiative to tackle the opioid crisis in America must include a robust effort to screen, vaccinate, and treat people for HBV and HCV. NVHR therefore urges the Commission to integrate the following recommendations into its final report.

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[1] Centers for Disease Control and Prevention, "Hepatitis C Kills More Americans than Any Other Infectious Disease" (May 2016), available at https://www.cdc.gov/media/releases/2016/p0504-hepc-mortality.html.
[2] Campbell, Canary, Smith, et al. State HCV Incidence and Policies Related to HCV Preventive and Treatment Services for Persons Who Inject Drugs — United States, 2015–2016. MMWR MORB MORTAL WKLY REP 2017;66:1-2.
[3] *Id*.
[4] Centers for Disease Control and Prevention, "Surveillance for Viral Hepatitis – United States, 2015" (June 2017), available at https://www.cdc.gov/hepatitis/statistics/2015surveillance/commentary.htm.

1. Optimize all health care interventions by linking individuals with opioid use disorders (OUDs) to screening, vaccination, treatment, and care for hepatitis B and C.

NVHR applauds the Commission's recommendations that the federal government eliminate barriers to opioid use disorder (OUD) treatment for Medicaid-eligible populations and expand access to medication-assisted treatment (MAT) and naloxone. We urge the Commission to further recommend that health care providers who treat individuals with OUDs and who prescribe naloxone also screen these individuals for HBV and HCV, vaccinate them against HBV, and, if positive, link them to HBV and HCV treatment and care.

As the Commission notes in its Draft Interim Report, MAT is proven to reduce overdose deaths. Screening and treating recipients of MAT for infectious diseases may also prevent the spread of HBV and HCV. Health care providers who dispense MAT or naloxone to individuals with OUDs have an invaluable opportunity to test and treat individuals who are at risk for contracting and transmitting HBV/HCV. Such opportunities should be maximized as avenues to curb the spread of the viruses and prevent HBV/HCV-related suffering and death. Seeking and receiving treatment for OUD may be an individual's first or only interaction with the health care system. It is imperative that health care providers be equipped to test, vaccinate, and treat for HBV and HCV during that crucial interaction. Coordination of HBV/HCV-related services with OUD treatment services is a vital component of the comprehensive public health strategy needed to combat the opioid crisis.

2. Legalize and expand access to syringe service programs (SSPs).

Syringe service programs (SSPs) are proven effective not only in preventing HBV, HCV, and HIV infections, but also in motivating people who inject drugs to enter OUD treatment. One study revealed that participants in an SSP were five times more likely to enter drug treatment than non-participants.[5] Research has also confirmed that SSPs neither encourage individuals to initiate drug use nor increase the frequency of drug use.[6] In the above study, SSP participants were more likely than non-participants to stop using drugs and to remain in treatment.[7]

Case managers at SSPs are uniquely positioned to help guide individuals into counseling and treatment. In one study, SSP participants who interacted with case managers were 87 times more likely to enter drug treatment within one week of referral than individuals who lacked

[5] Hagan, et al. Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *J Subst Abuse Treat*. 2000 Oct;19(3):247–52.
[6] The National Academies of Sciences, Engineering, and Medicine, Committee on a National Strategy for the Elimination of Hepatitis B and C, A National Strategy for the Elimination of Hepatitis B and C: Phase II Report (March 2017), available at http://www.nationalacademies.org/hmd/Activities/PublicHealth/NationalStrategyfortheEliminationofHepatitisBandC.aspx.
[7] Hagan, *supra* note 5.

such support.[8] With adequate funding and resources, case managers could also screen and vaccinate the same individuals for HBV and HCV and ultimately link these individuals to the treatment and care they need. Inclusion of such services at SSPs would halt the spread of HBV and HCV and protect the community at large.

Unfortunately, SSPs remain illegal in multiple states; one study identified 18 states as lacking laws that authorize comprehensive access to syringe services.[9] Laws authorizing comprehensive access to SSPs are especially absent in rural areas suffering acutely from the opioid crisis.[10] The nonpartisan National Academies for Sciences, Engineering, and Medicine has recommended that states act now to expand access to SSPs.[11] The Commission should urge state and federal agencies to adopt the National Academies' recommendation and to legalize and fund SSPs, with the end goal of steering individuals into OUD treatment and connecting them with HBV/HCV screening, treatment, and care.

3. Establish and invest in treatment alternatives to incarceration.

Incarcerating individuals with OUDs will not ease the opioid crisis. In fact, arresting and imprisoning people who inject drugs most often prevents them from accessing treatment. Moreover, upon their release from prison, individuals with OUDs are at extremely high risk for relapse and overdose. One study found that overdose was the leading cause of death among former inmates, with many of them dying within only two weeks of their release.[12] In 2015, law enforcement officers arrested approximately 1.2 million people for drug possession.[13] This number represents 84 percent of all arrests for drug law violations; only 16 percent of arrests were for selling or manufacturing a drug.[14] The United States currently incarcerates nearly half of a million people for drug offenses.[15] Many of these people suffer from OUDs and desperately need treatment to help them and their families heal, not punishment that may hasten their deaths from overdose or withdrawal.

The Commission should recommend that the federal government fund alternatives to incarceration like the Law Enforcement Assisted Diversion (LEAD) program, which is proven effective in steering individuals toward treatment and away from the costly cycle of arrest, prosecution, and incarceration. The LEAD initiative gives police officers discretionary authority to redirect individuals who use drugs into community-based treatment programs, instead of

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[8] Strathdee, et al. Facilitating entry into drug treatment among injection drug users referred from a needle exchange program: Results from a community-based behavioral intervention trial. *Drug Alcohol Depend*. 2006 Jul 27; 83(3): 225–32.
[9] Campbell, *supra* note 2.
[10] *Id*.
[11] The National Academies of Sciences, Engineering, and Medicine, *supra* note 6.
[12] Binswanger I, et al. Release from Prison — A High Risk of Death for Former Inmates. *N Engl J Med*. 2007 Jan 11; 356(2): 157–65.
[13] Drug Policy Alliance. Drug War Statistics (2017), available at http://www.drugpolicy.org/drug-war-statistics.
[14] *Id*.
[15] The Sentencing Project, Trends in U.S. Corrections (2017), available at file:///C:/Users/epauk/Downloads/Trends-in-US-Corrections%20(2).pdf.

transferring them for prosecution and detention. Police and prosecutors work closely with case managers to ensure that individuals with OUDs complete intensive treatment programs, which can also connect them to critical health services such as HBV and HCV screening and care. One study revealed that LEAD participants were 58 percent less likely to be re-arrested than non-participants over a five-year period.[16] In addition, the costs associated with participation in LEAD were substantially lower than the costs incurred by an individual's involvement in the criminal justice system.[17]

Incarcerating people with OUDs not only denies them access to drug treatment, but also exposes them to infectious diseases like HBV and HCV. An estimated one in three individuals in U.S. jails and prisons has HCV.[18] In state prisons, which incarcerate about 90 percent of all prisoners in the U.S., fewer than 1 percent of prisoners with HCV are receiving treatment.[19] Imprisoning people who inject drugs, who are at high risk for HBV and HCV, will increase the numbers of infected inmates and further burden states with providing expensive HCV treatment. In addition, high-risk behavior within prisons, such as drug use and tattooing, will lead to more infections and higher medical costs.

We urge the Commission to recommend that the federal government fund cost-effective treatment alternatives to incarceration like LEAD programs, and to acknowledge that punishment cannot serve as treatment for individuals with OUDs.

4. Protect Medicaid and the Affordable Care Act.

Medicaid is the single largest payer for behavioral health services in the United States.[20] Nearly 12 percent of Medicaid beneficiaries over the age of 18 have a substance use disorder (SUD).[21] Medicaid accounts for 21 percent of health care spending on treatment for SUDs[22] and between 35 and 50 percent of spending on MAT for OUDs.[23] As the Commission noted in its Draft Interim Report, enhancing access to MAT is key to eliminating the opioid epidemic.

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[16] Collins, et al. LEAD Program Evaluation: Recidivism Report (March 2015), University of Washington – Harborview Medical Center, available at http://leadkingcounty.org/lead-evaluation/.
[17] *Id*.
[18] Hepatitis C and Incarceration, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION (Oct. 2013), http://www.cdc.gov/hepatitis/HCV/PDFs/HepCIncarcerationFactSheet.pdf.
[19] Beckman, et al. New Hepatitis C Drugs Are Very Costly And Unavailable To Many State Prisoners. *Health Aff* 2016;35:893–1901.
[20] Centers for Medicare and Medicaid Services, Behavioral Health Services, available at https://www.medicaid.gov/medicaid/benefits/bhs/index.html.
[21] *Id*.
[22] *Id*.
[23] Families USA, How the Affordable Care Act Has Made It Easier to Get Mental Health and Substance Use Care (January 2017), available at http://familiesusa.org/blog/2017/01/how-affordable-care-act-has-made-it-easier-get-mental-health-and-substance-use-care.

People who live in rural areas, which have been especially ravaged by the opioid crisis, depend heavily on Medicaid for their health coverage. About 23 percent of rural residents are Medicaid beneficiaries.[24] In states that have expanded Medicaid, that number increases to about 26 percent.[25] In Kentucky and West Virginia, which have been disproportionately overwhelmed by the opioid epidemic, 39 percent and 32 percent of rural residents, respectively, are enrolled in Medicaid.[26] States that expanded Medicaid can treat more individuals with OUDs who would otherwise be ineligible for coverage.[27]

In addition, under the Affordable Care Act (ACA), treatment for SUDs is a required benefit in all Marketplace plans. The ACA requires insurers to offer equal coverage for SUD treatment and prohibits insurers from discriminating against people with SUDs or with a history of SUDs.

Without the protections of Medicaid and the ACA, individuals with OUDs would be unable to access lifesaving treatment like MAT. Health care providers who treat these individuals would also miss the critical opportunity to screen, vaccinate, and treat them for HBV and HCV. The Commission should urge states that have not already expanded Medicaid to do so in order to expand treatment to more individuals with OUDs. The Commission should also recommend that the government continue funding Medicaid at current levels so that people with OUDs do not lose access to treatment. Finally, the Commission should recommend that the ACA's protections of people suffering from OUDs remain intact. Maintaining the protections of Medicaid and the ACA is integral to ensuring that individuals with OUDs receive health care services that will save their lives, like MAT and screening for HBV and HCV. These protections will prove critical in winning the battle against opioid addiction and the corresponding epidemics of HCV and HBV.

Thank you, again, for the opportunity to comment on the Commission's Draft Interim Report. We ask that you give thoughtful consideration to the recommendations outlined above. Please contact Elizabeth Paukstis, Public Policy Director at the National Viral Hepatitis Roundtable (202-306-9779; epaukstis@nvhr.org), if we can be of further assistance.

Respectfully submitted by,

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[24] Families USA, Cutting Medicaid Would Hurt Rural America (March 2017), available at http://familiesusa.org/product/cutting-medicaid-would-hurt-rural-america.
[25] *Id*.
[26] *Id*.
[27] Kaiser Family Foundation, Medicaid and the Opioid Epidemic: Enrollment, Spending, and the Implications of Proposed Policy Changes (July 2017), available at http://files.kff.org/attachment/Issue-Brief-Medicaid-and-the-Opioid-Epidemic-Enrollment-Spending-and-the-Implications-of-Proposed-Policy-Changes.