MAT Leadership Council

May 18, 2022

Chairman Pallone, Ranking Member McMorris Rodgers, and members of the Committee,

The Medication-Assisted Treatment Leadership Council (MAT LC) voices it strong opposition to H.R. 1384, the Mainstreaming Addition Treatment Act (MAT Act), which is being offered as an amendment to H.R. 7666. MAT LC is comprised of more than 550 Opioid Treatment Program (OTP) facilities and Office-Based Opioid Treatment (OBOT) practices across 45 states. Our health care teams provide lifesaving care to more than 150,000 patients suffering from opioid use disorder (OUD) every day.

It is critical that the Subcommittee understand that medication alone is not treatment. Medication merely helps to stabilize OUD patients, allowing them to receive the behavioral health services that are critical to recovery. OTPs are required, by law, to provide counseling to our patients. Those who are new to treatment or not succeeding in treatment receive more frequent counseling. Our patients are also subject to at least eight random toxicology screens each year. This ensures that medication is being properly used and that illicit drug use is not continuing – both of which help guide clinical decision-making. Lastly, OTPs are required to employ robust anti-diversion measures to protect patients from abusing the medication or selling it in the community.

Many of our companies also operate OBOTs, where patients receive medication as well as the full suite of MAT services (counseling, testing, training, etc.) that they would receive in the OTP setting. We believe this fact distinguishes our OBOTs from many of the OBOTs across the country that do not offer the full suite of MAT services and supports. Often times, patients only get medication, usually buprenorphine, in the OBOT setting. Unlike OTPs, OBOTs do not have to provide or refer for counseling and are not required to use toxicology testing to ensure patients are taking the buprenorphine they are being prescribed. OBOT providers are required to have just eight hours of online training on buprenorphine and little or no training in addiction medicine. The only large study of OBOTs concluded that "the quality of care received seemed generally poor."[1] This is not an indictment on these providers so much as it is evidence that many are simply not trained adequately and do not have the requisite resources to deal with complex patients who are suffering from OUD. Our OBOTs, however, are built on the OTP model which places an emphasis on ensuring patients receive more than just medication and benefit from the behavioral support system in place to ensure the greatest likelihood of

[1] Gordon, et al, "Patterns and Quality of Buprenorphine Opioid Agonist Treatment in a Large Medicaid Program," Journal of Addiction Medicine, 2015.

recovering. Our OBOTs are not required to provide counseling, toxicology screening, or employ anti-diversion programs, but they do because we know, through decades of experience, this is the level of care patients suffering from OUD need.

In 2000, Congress sought to expand OUD treatment to the physician office setting. In exchange for forgoing significant oversight and regulation, Congress placed a limit on the number of OUD patients each OBOT physician could treat (30 in the first year, up to 100 beginning in year two). The patient limits were put in place to ensure that these physicians, many of whom have little training in addiction treatment or relationships with mental health providers, did not become unregulated addiction treatment practices.

In 2018, Congress passed the SUPPORT Act which vastly expanded these patient limits. Physicians can now prescribe up to 275 patients after just eight hours of online training – a 175% increase over the previous limit. This means that, currently, physicians can treat 14 patients per day for opioid addiction if the physician sees each patient just once per month (many of these complicated patients should be seen more frequently than once per month). Two-thirds of the highly specialized OTPs across the country treat fewer than 200 patients.

The SUPPORT Act also allowed nurse midwives, nurse anesthetists, and other mid-level clinicians to prescribe buprenorphine to OUD patients. There is no requirement that OBOT patients receive counseling for their addiction or receive random toxicology screenings. Congress opted for a massive expansion of opioid (buprenorphine) prescribing authority in the OBOT setting without any understanding if these patients were receiving quality care under the previous patient limits. We believe the current patient limits, which the MAT Act seeks to eliminate, are already set too high absent additional oversight, quality reporting, and training requirements. OTPs are not subject to patient limits because we are heavily regulated, as any addiction treatment center that prescribes opioids should be. The number of buprenorphine prescribers nearly doubled between July 2019 and June 2020. Congress and HHS have no idea what level of treatment is being provided by these practitioners, what overdose rates look like, or what retention rates are in OBOTs.

Policymakers should question whether special interests seeking to eliminate the patient limits and federal oversight are simply trying to take advantage of the pandemic to grow their revenue. Consider that there are currently roughly 120,000 physicians and clinicians waivered to prescribe buprenorphine to more than 7.5 million patients. That is more than triple the number of patients who are estimated to suffer from OUD. The number of prescribers and their prescribing authority already dwarfs those who are actually in need. Deregulating OBOTs will do nothing to expand access to care as more than 99% of people live in an area where the nearest buprenorphine prescriber is 30 miles or less away. The more likely scenario is that buprenorphine pill mills will flourish and buprenorphine diversion will push patients away from seeking treatment.

The MAT LC firmly believes that if Congress wants to expand access to buprenorphine, it should find was to do so in the 1% of the country that does not have a prescriber, rather than eliminate all DEA and SAMHSA oversight and regulation for the 99% of the country that does. At a minimum, practitioners seeking to prescribe to more than 275 patients should be required to obtain certification and licensure as a drug treatment facility from CARF or JCAHO. Again, the **MAT LC strongly opposes H.R. 1384**, **the *Mainstreaming Addiction Treatment Act of 2021*** until it is changed to incorporate policies that will protect patient care.