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Testimony to the House Energy and Commerce Health Subcommittee Hearing

Combatting an Epidemic: Legislation to Help Patients with Substance Use Disorders

March 3, 2020

**Mark W. Parrino, MPA
President**

I am writing to express the views of the American Association for the Treatment of Opioid Dependence (AATOD) before the House Energy and Commerce Health Subcommittee. AATOD represents over 1,000 Opioid Treatment Programs (OTPs) throughout the United States. OTPs are the comprehensive care outpatient treatment programs, which specialize in the treatment of Opioid Use Disorder (OUD). All of these treatment programs operate under the regulatory authority of the Substance Abuse and Mental Health Services Administration through accreditation oversight and by the Drug Enforcement Administration. The States also provide oversight to the OTPs through the State Opioid Treatment Authorities and through other state licensing boards.

The OTPs are required to provide comprehensive care to patients with Opioid Use Disorder in addition to using the three federally approved medications to treat this disorder.

The Implementation of a New Medicare Reimbursement Rate for OTPs

At the outset, our Association’s members want to express our appreciation to the House Energy and Commerce Health Subcommittee for all of its work in 2018 in authorizing the development of the first ever Medicare reimbursement rate for OTPs in the United States. It will make a profound difference in the lives of Medicare eligible patients entering and remaining in treatment. Our Association’s membership is currently working with CMS Medicare representatives, during the early implementation of this work, which became effective January 1, 2020.



Mainstreaming Addiction Treatment (MAT) Act

I am attaching two documents, which explain our views on this particular legislation.

The first document is a Fact Sheet, which clearly is an opposition to H.R. 2382 and S. 2074. There are two particular citations that are useful to point out with regard to the misuse of buprenorphine in the United States “There are no data on the efficacy or quality of MAT provided in primary care settings. There is, however, data available on the rates of misuse and risks of overdose associated with buprenorphine. The RADARS® (Researched Abuse Diversion Addiction Related) surveillance system found that during 2018, individuals presenting for opioid treatment in the U.S. reported **misuse of buprenorphine** in 27.4% of cases and within these, 15.3% indicated **misuse of buprenorphine** by injection (unpublished data on file).”

It is also important to reference the graph at the end of this Fact Sheet, “Misuse of Pain Reliever Subtypes in Past Year among Persons Aged 12 and Up”. According to the graph, buprenorphine registers greater misuse of pain reliever subtypes in the United States at 30%. This graph represents a report from the National Survey on Drug Use and Health as published by SAMHSA in 2018.

The DATA 2000 Waiver Training

H.R. 2482 seeks to remove the eight-hour training and any of the reporting requirements under DATA 2000. Proponents of this legislation indicate that this eight-hour training is a barrier to increasing access to buprenorphine prescribing. This is not the case. Additionally, proponents of this legislation indicate that medical practitioners do not need any special training to prescribe OxyContin or other opioids to treat pain. I do not believe that Congress needs to be reminded of how our country got into the opioid epidemic. While pharmaceutical companies are in the news with regard to paying fines for their role in marketing opioids, the role of the physicians in writing the prescriptions has been largely overlooked. Congress should be careful not to assume that medical practitioners understand how to treat opioid use disorder without appropriate training and quality of care guidelines/requirements.

I am referencing a Fact Sheet with regard to clinicians taking the MAT Waiver training as released by the American Academy of Addiction Psychiatry (AAAP) and their Providers Clinical Support System (PCSS). In reading through the chart, it should be noted that there has been a 404% increase in MAT Waiver trainings from 2017 to 2019. Clearly, this is not supporting the concept of the eight-hour training being an impediment. In reading through a survey of the MAT waiver participants, who have taken the waiver course, 83 % indicated that they needed to know more about the topic.

From our Association's point of view, and as expressed in the AAAP Fact Sheet, the eight-hour training requirement is not a barrier. The barriers exist in preauthorization insurance requirements. Another barrier is the lack of having clinical support services for DATA 2000 practitioners. This is why our Association has always supported the Vermont "Hub and Spoke" Model, which fully coordinated care with OTPs and DATA 2000 practitioners in addition to managing clinical support services.

What We Know About Quality of Care in DATA 2000 Practices

A Federal Register Notice was published by the Substance Abuse and Mental Health Services Administration (SAMHSA) when practitioners were allowed to treat up to 275 patients following a year of treating 100 patients. SAMHSA is required to obtain information from all such practitioners with regard to some basic reporting data, which include the number of patients in treatment, the clinical services that are offered to patients and other diversion control measures. Our Association has not been aware of how many practitioners have submitted such data or if such data are tracked in any consistent way. The Association encourages SAMHSA and other related agencies to actively track this information and report it out publicly.

It is also important to point out that there has been an extraordinary increase in the number of practitioners, who can prescribe buprenorphine to treat buprenorphine disorder over the past 15 months including physician assistants nurse practitioners, and midwives. Has SAMHSA evaluated how this has impacted the quality of care in treating patients?

It is equally important to point out that patients with Opioid Use Disorder are comorbid with Hepatitis B and C in addition to HIV infection. Such patients also have histories of anxiety or depressive disorders in addition to other mental health challenges that need access to integrated care models to work in conjunction with DATA 2000 practices.

If H.R. 2482 and S. 2074 are passed, the existing patient cap would be removed, in spite of the fact that we do not have any published information on the kind of services that are offered within such DATA 2000 practices. As a prior Director of the Center for Substance Abuse Treatment (Dr. H. Westley Clark) pointed out, eliminating the patient cap will open the door to buprenorphine "pill mills". We are still in the midst of a changing opioid use epidemic, which has shifted from prescription opioid misuse to heroin use and more currently fentanyl use combined with methamphetamine use. This is not a time to be removing clinical training requirements, which are at best, quite simple. It is also a time when we need to have better information about how treatment is functioning in the United

States rather than decreasing reporting requirements or eliminating the cap on the number of patients that can be responsibly treated.

We also recommend that Congress consult with the Substance Abuse and Mental Health Services Administration, the Drug Enforcement Administration and State Opioid Treatment Authorities to determine where there have been explicit reports about the quality of care and regulatory compliance issues with DATA 2000 practices.

Advancing the Work of Criminal Justice

There is a greater interest from correctional facilities and other parts of the criminal justice system including drug courts, to increase the use of Medication-Assisted Treatment for opioid use disorder. AATOD has been working with a number of policy partners in this endeavor including the Legal Action Center, the National Commission on Correctional Health Care, the American Correctional Association, the National Association of State Alcohol and Drug Abuse Directors and other policy partners throughout this system of care.

We have been working in conjunction with a number of these policy groups including the National Association of Drug Court Professionals and some of their statewide chapters to increase the opportunities of training such drug court judges. We are also working with our colleagues in a number of states to increase access to Medication-Assisted Treatment in correctional facilities. Recent models in Connecticut and Rhode Island are building on models offered in the Philadelphia prison system, Baltimore prison system and New York City jail (Rikers Island) and are certainly moving in the right direction. Accordingly, there has been a 55% decrease in post release recidivism, as reported in Rhode Island, in addition to a 60% reduction in post release mortality as inmates are transitioned from the correctional environment into an outpatient substance abuse treatment setting.

This is all very encouraging news and we encourage the House to support such measures. This is why we are supporting Congresswoman Kuster's bills in order to provide funding to the Department of Justice at \$50 million per year to increase access to Medication-Assisted Treatment in the correctional setting for four consecutive years. Our Association is also supporting Congresswoman Kuster's bill, "The Humane Correctional Health Care Act".

Expanding Access to Treatment in Rural and Underserved Settings in the United States

We are working with the Office of National Drug Control Policy (ONDCP) and the Department of Agriculture on rural drug treatment initiatives. The Drug Enforcement Administration (DEA) has just released new regulations to expand

the use of mobile vans in conjunction with Opioid Treatment Programs. This will expand the reach of OTPs in rural and suburban settings so that patients will not have to travel great distances to get to OTPs.

We are also encouraging the Substance Abuse and Mental Health Services Administration to provide guidance to Opioid Treatment Programs in expanding access to telehealth/telemedicine services. Once again, if such guidance were to be promulgated, we believe that it would increase access to care in rural and underserved areas connecting into OTPs.

Finally, we also believe that expanding access to the “bricks and mortar medication units” working in conjunction with OTPs will also expand such services. The goal here is to provide increased access to care to patients in need of treatment in such rural and underserved areas of the United States.

Expanding Access to Medicaid Reimbursement for Medicaid Eligible patients in OTPs.

At the present time, there are still eleven states that do not provide any Medicaid reimbursement for Medicaid eligible patients, who are treated in OTPs. I am providing a listing of these eleven states.

We appreciate what the House has done in passing the SUPPORT Act and understand that such Medicaid reimbursement must be required by October 2020. We encourage the House to provide oversight in working with federal agencies, which have jurisdiction in this area in addition to the State Medicaid Authorities to require that comprehensive Medicaid reimbursement is established for Medicaid eligible patients, participating in OTPs.

In the interest of time and in offering this testimony, our Association is focused on some of the leading issues affecting access to care for the treatment of Opioid Use Disorder in the United States. We understand that there are a number of bills under consideration and we look forward to working with the House Energy and Commerce Health Subcommittee as these bills are considered.

Thank you for accepting this testimony and incorporating it into the Congressional record. We are also pleased that our Association will be represented through Margaret Rizzo’s testimony. Ms. Rizzo is the Board Delegate to the AATOD Board of Directors from New Jersey and serves as the Executive Director of the JSAS Healthcare OTP in Neptune, New Jersey.



American Association for the Treatment of Opioid Dependence, Inc.

The Mainstreaming Addiction Treatment (MAT) Act: Consider the Facts

Don't make important policy decisions without good data. Examine what is happening in our own country before eliminating training and oversight.

OPPOSE H.R. 2482 and S. 2074

The MAT Act “Fact” Sheet	✓ FACT CHECK
<p>“For two decades, buprenorphine has been used as a safe, effective and life-saving medication-assisted treatment (MAT) for individuals suffering from a substance use disorder.”</p>	<p>It’s true that buprenorphine, in combination with psychosocial services, has been effectively used for two decades. However, the vast majority of individuals currently receive no counseling. This has led to lower treatment retention and poor clinical outcomes.^{1,2} Simply prescribing medication alone is not MAT.</p>
<p>“Medical professionals need a special DEA waiver to prescribe buprenorphine to treat substance use disorder, which leads to treatment bottlenecks and a lack of providers.”</p>	<p>No such bottleneck exists. SAMHSA approves applicants within 45 days. There are currently more than 72,000 waived prescribers approved to treat 4.3 million patients.³ This is more than double the number of estimated individuals living with an opioid use disorder in our country. However, only about half of the waived medical practitioners are actually prescribing.⁴</p>
<p>“This outdated waiver requirement has stuck around even though medical professionals can prescribe the same drug for pain without jumping through bureaucratic hoops.”</p>	<p>Federal and state authorities have been working urgently to implement prescribing limits and increase prescriber education to mitigate the practices that led to the current opioid epidemic. This legislation moves in the opposite direction by removing education requirements and limits, making it easier to prescribe a medication known to be highly diverted and misused.</p>
<p>“Removing this barrier will massively expand treatment access, making it easier for medical professionals to integrate substance use disorder treatment into primary care settings.”</p>	<p>Eliminating the waiver and training requirements will massively expand access to *medication*, not *treatment*. This legislation does not provide medical professionals with the resources needed to integrate quality substance use disorder treatment into their settings. Only 8% of American medical schools offer education on addiction.⁵ Yet this legislation will reduce education for medical professionals wishing to treat this disorder.</p>
<p>“After nearly 20 years of safe treatment, there is no good reason to maintain a separate, more burdensome regulatory regime restricting access to safe, proven addiction treatments including buprenorphine.”</p>	<p>There are no data on the efficacy or quality of MAT provided in primary care settings. There is, however, data available on the rates of misuse and risks of overdose associated with buprenorphine.⁶ The RADARS® (Researched Abuse Diversion Addiction Related) surveillance system found that during 2018, individuals presenting for opioid treatment in the U.S. reported misuse of buprenorphine in 27.4% of cases and within these, 15.3% indicated misuse of buprenorphine by injection (unpublished data on file).</p>

¹T McLellan, A & O. Arndt, Isabelle & Metzger, David & Woody, George & O'Brien, Charles. (1993). The Effects of Psychosocial Services in Substance-Abuse Treatment. JAMA: the journal of the American Medical Association. 269. 1953-9. 10.3109/10884609309149701

² Principles of Effective Treatment, A Research Based Guide (3rd Edition), National Institute on Drug Abuse, last update January 2018

³ Practitioner and Program Data, SAMHSA, <https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-program-data>

⁴ The SAMHSA Evaluation of the Impact of the DATA Waiver Program, Summary Report, March 30, 2006

⁵ Hoffman, Jane. “Most Doctors are Ill-Equipped to Deal with the Opioid Epidemic: Few Medical Schools Teach Addiction.” *New York Times (New York)* 10, September, 2018.

⁶ Lofwall, M.R, Walsh, S. L. 2014. A review of buprenorphine diversion and misuse: the current evidence base and experiences from around the world. *Journal of Addiction Medicine*. Sep-Oct;8(5):315-26.

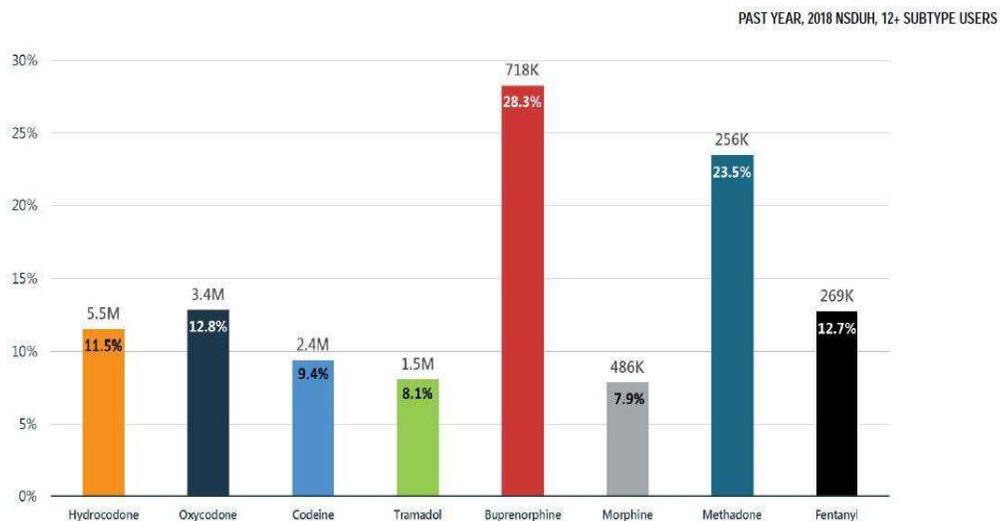


American Association for the Treatment of Opioid Dependence, Inc.

The Mainstreaming Addiction Treatment (MAT) Act: Consider the Facts

The MAT Act “Fact” Sheet	✓ FACT CHECK
<p>“The additional waiver requirement reflects a longstanding stigma around substance use treatment and sends a message to the medical community that they lack the knowledge or ability to effectively treat a patient with substance use disorder.”</p>	<p>The stigma surrounding MAT for opioid use disorder is generated in large part when diversion and misuse of these medications occur. Diversion control plans are not required of MAT provided in a primary care setting. The rate of buprenorphine diversion has been steadily increasing as more buprenorphine is prescribed.⁷ The number of opioid treatment admissions reporting buprenorphine as a primary drug of MISUSE has also steadily increased.⁶</p>
<p>“Practitioners are already required to obtain a license to prescribe controlled substances and meet any state-level requirements to prescribe buprenorphine.”</p>	<p>The requirement to obtain a license has already proven insufficient to ensure safe prescribing practices. A prior lack of adequate training and best practice guidelines for pain management and opioid prescribing led to inadvertently bad prescribing outcomes and deaths. Practitioners are not trained to use opioid treatment medications. The waiver requirement helps protect consumers from untrained practitioners inappropriately prescribing powerful opioids.</p>
<p>“After France took similar action to make buprenorphine available without a specialized waiver, opioid overdose deaths declined by 79 percent over a four-year period.”</p>	<p>This legislation fails to address key differences between France and the model that would be created in the U.S. as a result of this legislation. In France, practitioners can only prescribe for seven days at a time and must specifically justify a longer duration. No such limits exist in the U.S. where schedule III drugs like buprenorphine can be refilled up to 5 times without requiring a new prescription. Pharmacies in France supervise administration for the induction period and for some time beyond. U.S. pharmacies are not equipped to oversee daily administration of medication to patients. Also, widespread co-prescribing of benzodiazepines in France suggests a need for more practitioner training: “further efforts to improve the safety of buprenorphine are warranted, and potential means for achieving this goal in France include increased control of buprenorphine prescriptions, physician training on the risks of excessive dosing and co-prescription of other psychotropics with buprenorphine (especially benzodiazepines)”⁸ Exactly what this legislation would remove.</p>

Misuse of Pain Reliever Subtypes in Past Year among Persons Aged 12 and Up⁹



⁷ Treatment Center Programs Combined, 2008-2018, RADARS® (Researched Abuse Diversion Addiction Related)

⁸ Auriacombe M, Fatseas M, Dubernet J, et al. French field experience with buprenorphine. American Journal on Addictions. 2004;13:S17–28

⁹ The National Survey on Drug Use and Health: 2018, SAMHSA



States that Do Not Provide Medicaid Reimbursement January 2019

As of January 2019, there are 11 states without Medicaid reimbursement. The following list is for non-Medicaid reimbursement states.

- Arkansas
- Idaho
- Iowa
- Kansas
- Louisiana
- Mississippi
- Montana
- North Dakota *
- Oklahoma
- Tennessee
- Utah

* North Dakota was using STR funds to pay for Medicaid eligible patients but that is not the same as Medicaid reimbursement, which is why they are included on the list.