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On Behalf of the American Psychiatric Association

Before the U.S. House of Representatives

Health Subcommittee of the House Energy and Commerce Committee

COMBATTING AN EPIDEMIC:

LEGISLATION TO HELP PATIENTS WITH SUBSTANCE USE DISORDERS

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Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the Energy and Commerce Health Subcommittee, thank you for allowing me the opportunity to serve on today's panel. My name is Dr. Smita Das, I am currently a Clinical Assistant Professor of Psychiatry and Behavioral Sciences at Stanford University. My testimony today is on behalf of the American Psychiatric Association (APA), an organization representing 38,800 psychiatrists including addiction psychiatrists.

The APA is dedicated to providing psychiatrists with education and training on the most modern evidence-based treatment to address the diagnoses and treatment of patients with substance use disorders (SUDs). As an active partner in the Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) administered through the Substance Abuse and Mental Health Services Administration (SAMHSA), thousands of psychiatrists have received training on the most effective models and medications used for treating an opioid use disorder. In addition, through funding from Opioid State Targeted Response Grants made available by the 21st Century Cures Act passed in 2016, the APA participates in a coalition of 22 national health care associations working to expand the availability of opioid use disorder treatment by partnering with states and communities to support implementation of evidence-based practices in prevention, treatment and recovery of opioid use disorders. Through these programs, we've received increased interest in education and training resources to help clinicians treat this patient population, often with comorbid conditions and polysubstance use.

Addiction is a chronic brain disorder that can be effectively treated. With your help, we have made strides in reversing the upward trend of opioid overdose deaths and reducing stigma surrounding addiction over the past few years, and these efforts must continue as there is more to be done.

While the most recent National Survey on Drug Use and Health[1] (NSDUH) found a decrease in prescription opioid misuse across all age brackets for 2018 – falling from 11.4 million in 2017 to 10.3

[1] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality,

million in 2018, it also found that an estimated 19.3 million Americans 18 and older suffer from substance use disorders (which include opioids and other illicit drug and alcohol use). Clinicians need the support and ability to continue to address the opioid crisis, while also focusing on fentanyl overdose deaths, methamphetamine use, alcohol abuse, tobacco cessation, and marijuana use.

It is important to note that substance use disorders rarely happen in a silo. The same NSDUH survey also found that 47.6 million Americans 18 and older have mental illnesses. The linkages between substance use disorders and cooccurring mental illness is significant, with 9.2 million people aged 18 and older suffering from both substance use disorders and mental illnesses. People with substance use disorders are also more likely to have physical comorbidities like chronic pain, cancer, heart, and liver disease. The prevalence of comorbidities increases the need for more integrated care and for all physicians to be aware of the risk and impact of substance use disorders. Psychiatrists are uniquely positioned to treat this population, with the ability to diagnose and treat co-occurring psychiatric disorders, and recognize suicide risk, which is elevated amongst those with substance use disorders.[2] However, given the psychiatric workforce shortage, it is essential that other physicians are also able to treat substance use disorders to assist in closing the tremendous gaps in access to care for these patients.

Only 1 in 13 people who need substance use treatment actually receive care. That's 17.5 million who need treatment but are not getting it. We will not be able to end the opioid epidemic if we do enable patients to receive the care that they need. To close this treatment gap, a multipronged approach is necessary. This includes increasing workforce capacity, ensuring coverage of substance use disorder treatment is on par with physical illnesses, implementing innovative models to improve access and reducing stigma. The APA and our members can serve as a resource as you continue to craft legislation to

Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/ on 2/26/20

[2] Oquendo MA, Volkow ND. Suicide: A silent contributor to opioid overdose deaths. NEJM 2018; 378:1567-1569.

accomplish these things and close the treatment gap. Though there is still much to do, I would like to talk about some of the things Congress has done that the APA supports and that are working.

I especially want to thank the Committee for working last Congress to pass HR 6, the *SUPPORT for Patients and Communities Act* in December of 2018. The APA was particularly supportive of a number of provisions in the bill, including: requiring the Drug Enforcement Administration to update the Ryan Haight Act to allow for special registration enabling physicians to prescribe controlled substances via telemedicine without an in-person exam. The APA also supported HR 6 provisions that improved SUD screening and coverage for Medicare beneficiaries. Further, APA supported the investments in the SUD treatment workforce through loan-repayment that were made possible by HR 6. In addition, APA strongly supported steps that HR 6 took to reduce barriers to the use of telehealth for patients with substance use disorders and co-occurring mental health conditions. We urge Congress to go one step further and also remove these barriers for individuals suffering from mental health disorders. Finally, APA supported provisions in HR 6 that improve SUD patient transitions from the criminal justice system back into the general population through Medicaid coverage for juveniles. These are just a handful of things the APA supported in HR 6 and we look forward to building upon these improvements through your work on this Committee.

I would now like to address three areas related to the bills being discussed today to which I hope the Committee will continue providing priority attention.

First, I would like to address education and training for treating substance use disorders. There is currently minimal training for medical providers in substance use disorders compared to the high proportion of patients with untreated substance use disorders. It is important to be thoughtful about how to increase training across the continuum from medical school, to residency, and through continuing education. In addition, studies show that buprenorphine is an underutilized pharmacotherapy. A large number of physicians who have waivers to prescribe MAT are not prescribing to capacity due to lack of

time for additional patients, lack of belief in treatment efficacy, and insufficient reimbursement.[3] From our experience with training prescribers through PCSS, clinicians want more training, especially real-world experience, in treating substance use disorders given the complexity of some patients and the stigma associated with addiction.

Through PCSS and other programs, we have been working to try and improve education in residency programs and will continue to advocate for a thoughtful approach to prepare the workforce. However, part of the reason for the treatment need disparity is a shortage of physicians trained in addiction medicine, addiction psychiatry, or pain management. The lack of physicians trained in these specialties reflects the nation's larger physician shortages and the lack of incentives to pursue specialty addiction training. Funding new residency positions, expanding loan repayment and forgiveness, and offering incentives to work in underserved areas will strengthen the health care workforce and help mitigate the effects of the overall physician shortage and treatment gap. This is why the APA supports HR 3414, *the Opioid Workforce Act of 2019*, which is part of today's hearing.

Second, it is well known that the criminal justice system has become one of the largest de facto providers of mental health and substance use treatment. According to the Bureau of Justice Statistics, more than half of those in the criminal justice system suffer from a mental illness, while between one-half and three-quarters of inmates suffer from a substance use disorders.[4] Unfortunately, the Bureau also indicates that only one third of inmates with substance use disorders receive the treatment they need. Under federal law, both physical and mental medical care provided in correctional facilities is categorically ineligible for reimbursement under the Medicaid program. As mentioned previously, through passage of HR 6, the Department of Health and Human Services was directed to issue guidance on transitioning care for incarcerated individuals with substance use disorders and mental illness. Part of the goal of this

[3] Huhn AS, Dunn KE. Why aren't physicians prescribing more buprenorphine?. *J Subst Abuse Treat*. 2017;78:1–7. doi:10.1016/j.jsat.2017.04.005

[4] U.S. Dept. of Justice, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (Dec. 2006).

guidance, was to help guide states in ensuring that incarcerated individuals get the care and support they need to treat their SUDs and mental illnesses and to prevent recidivism when they are released from custody. With this backdrop, the APA supports the *Medicaid Reentry Act*, HR 1329, which gives states flexibility to allow incarcerated individuals to enroll in Medicaid prior to their release. Allowing Medicaid enrollment before discharge would decrease lapses in care that too often lead to tragic outcomes and would instead boost former inmates' ability to successfully re-enter their communities. HR 1329 is an excellent example of how using evidence-based policy to defragment care and coordinate services between support systems can work to support those with substance use disorders and other mental health issues to successfully re-enter their communities.

My third point is not the focus of this hearing, however, I would be remiss not to mention how lack of compliance with the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) law has aggravated the lack of access to substance use treatment. By requiring burdensome prior authorization paperwork, offering narrow and inaccurate networks of mental health providers and not covering medically appropriate, clinically necessary substance use disorder treatment, insurers are denying patients the ability to manage and overcome their substance use disorders. In addition, stigma in seeking help is already an enormous obstacle for patients. When you add stigma to an already administratively burdensome process to obtain coverage and reimbursement, it makes treatment that much more inaccessible to patients. We need to ensure that the intent of the MHPAEA, which has been the law for over 10 years now, is enforced appropriately and that patients are provided seamless and timely access to the life-saving treatment that they desperately need. I want to thank the Committee for working with the APA on this critically important issue.

In closing, as psychiatrists, we know that substance use disorders and co-morbid mental and physical illnesses are complex problems that require multidimensional solutions. These solutions must take into account individual patients as well as families and communities. I am encouraged that the

Committee has chosen to continue its focus on the opioid epidemic, and encourage the Committee to look beyond opioids and ensure consideration of all substance use disorders as it moves forward with these bills today and considers other legislation. The bottom line is that solutions to close the treatment gap for substance use disorder treatment must focus on increasing access, decreasing stigma, coordinating care, and working together to help our patients and communities recover from the impact that this crisis has had on our country.

Thank you again for inviting me here today to discuss this very important topic. The APA and I look forward to working with members of this Subcommittee to address substance use disorders and addiction more broadly. I am also happy to answer any questions you may have.