Testimony to the House Energy and Commerce Health Subcommittee Hearing –

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

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Thank you for inviting me today to testify. My name is Margaret Rizzo and I am the Executive Director/CEO of JSAS HealthCare. JSASHC is an opioid treatment program (OTP) located in Monmouth County, NJ. We are currently treating over 700 patients with opioid use disorder (OUD). Our agency has been treating this population since 1973, and this is my 29th year in the field. I am here to testify on the views of the American Association for the Treatment of Opioid Dependence (AATOD), of which I am the NJ Board Member.

AATOD represents over 1,000 Opioid Treatment Programs (OTPs) throughout the United States. OTPs are comprehensive care outpatient treatment programs, which specialize in the treatment of Opioid Use Disorder (OUD). All OTP's are under the regulatory oversight of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Drug Enforcement Administration (DEA) and are required to be accredited every three (3) years through a rigorous process from a SAMHSA-approved accreditation body. In addition, each State provides oversight to the OTPs through the State Opioid Treatment Authorities, state regulations and through other state licensing boards. Only OTP's are authorized to use all three federally approved medications to treat OUD in an outpatient setting.

At the outset, our Association's members want to express our appreciation to the House Energy and Commerce - Health Subcommittee for all 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.

[What We Know About Quality of Care in DATA 2000 Practices]

A Federal Register Notice was published by 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 is tracked in any consistent way. The Association encourages SAMHSA and other related agencies to actively track this information and report it out publicly.

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. 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.

H.R. 2482 seeks to remove the eight-hour training and any of the reporting requirements under DATA 2000. In reference from Fact sheets that you have received,? as released by the American Academy of Addiction Psychiatry (AAAP) and their Providers Clinical Support System (PCSS), 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 an eight-hour training being an impediment. As evidenced by a survey of the MAT-waivered 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 by AAAP 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.

For all of these reasons, we oppose the passage of H.R. 2482

H.R. 4141 [Humane Correctional Health Care Act] and H.R.1329 [Medicaid Reentry Act]

There is a greater interest from correctional facilities and other parts of the criminal justice system including drug courts, to increase the use of MAT for opioid use disorder. We have been working in conjunction the National Association of Drug Court Professionals and their statewide chapters to increase the opportunities for training drug court judges.

We are also working with our colleagues in a number of states to increase access to MAT in correctional facilities. Recent models in Connecticut and Rhode Island are building on models offered in Philadelphia and Baltimore prison systems and Rikers Island in NYC, and they 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. Furthermore, ensuring that newly released inmates have Medicaid coverage in place prior to their release as proposed in H.R. 1329 would improve access to the appropriate opioid use disorder treatment.

This is all very encouraging news and we encourage the House to support such measures. This is why we are supporting the passage of H.R. 4141 introduced by Congresswoman Kuster and H.R. 1329 introduced by Congressman Tonko.

Finally, [Expanding Access to Treatment in Rural and Underserved Areas 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 DEA has just released new regulations to expand the use of mobile vans in conjunction with OTP's. This will expand the reach of OTPs in rural and suburban settings so that patients will not have to travel great distances to receive life-saving treatment at an opioid treatment program.

We are also encouraging SAMHSA to provide guidance to OTP's 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 individuals to OTPs.

We also believe that expanding access of 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.

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.