Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Combatting an Epidemic: Legislation to Help Patients with Substance Use Disorders"
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The Honorable Frank Pallone, Jr. (D-NJ)

1. It seems like it would be very disruptive for someone in recovery for substance use disorder to have to stop and start their treatment as they move through the justice system-can you talk about how that can affect a person's recovery?

Detainment in correctional settings (jails and prisons) can pose treatment challenges for individuals with substance use disorder (SUD): those who are in treatment prior to incarceration may be forced to discontinue treatment, and those with untreated SUD are often not offered evidence-based and life-saving treatment upon entering jail[i] or prison. [ii] When we look specifically at opioid use disorder (OUD), forced opioid withdrawal – from prescribed agonist medication or illicitly obtained opioids – can cause harm and suffering to the inmate during incarceration and post-release. Deaths from complicated opioid withdrawal as well as relapses and opioid overdoses in correctional settings have been reported.[iii] Upon release, individuals whose OUD treatment has been discontinued are less likely to reenter treatment.[iv] For all inmates with OUD, incarceration without agonist medication treatment increases risk of post-release overdose death through reduced opioid tolerance. Remarkably, nearly five percent of all deaths from illicit opioids occurs among people who were released from jail or prison in the past month.[v]

Providing addiction treatment in correctional settings is challenging. Medicaid is prohibited by law from paying for health care in jails and prisons ("*the inmate exclusion clause*" of the 1965 Social Security Act), and Medicare regulations generally prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered. As a result, the correctional healthcare system is under-resourced, isolated from mainstream medicine, and not subject to standardized accreditation or quality reporting requirements.[vi]

Jails and prisons face different challenges to providing evidence-based medical care to detainees and inmates with SUD. Despite these challenges, access to SUD treatment within the correctional system is a critical public health and ethical issue. Research found that more than half of individuals with OUD reported a history of involvement in the criminal legal system,[vii]

demonstrating the potential impact that initiating treatment within correctional settings can have on the overall disease burden.[viii]

Taking OUD as an example again, we know that providing evidence-based treatment for OUD, including offering all FDA-approved medications, either on-site or through transport, benefits individuals who are incarcerated, corrections professionals, and the community at-large. Research has shown that starting or continuing methadone or buprenorphine for the treatment of OUD while incarcerated improves treatment entry and retention upon release and reduces post-release mortality.[ix,x,xi]

To be sure, treatment interruptions caused by involvement in the criminal justice system are clearly linked to relapse and death. By starting or continuing evidence-based treatment for individuals with SUD in correctional settings, and by ensuring a warm hand-off to community treatment providers upon release, we can support the health and recovery of justice-involved individuals and promote the health of the families and communities that depend on them.

This is why ASAM strongly supports the **Medicaid Reentry Act**, which would restart Medicaid coverage of medical services to eligible individuals up to 30 days prior to release. Reinstating Medicaid coverage before community reentry can help ensure individuals are receiving evidence-based treatment for their SUD and any co-occurring conditions as well as facilitate an uninterrupted transition to community treatment upon release.

2. Do you support additional training on safe opioid prescribing for health care professionals? If so, why do you believe that additional is necessary? If Congress is to consider a requirement for additional training for health care professionals that prescribe or dispense opioids, what elements should be considered as a part of such training? I know some in the past have expressed concern about the burden or cost that might be associated with additional opioid prescriber training. What are some of the ways these concerns could be addressed?

ASAM supports one-time, universal training in the recognition, diagnosis and treatment of addiction for all registered prescribers of controlled substances, unless those prescribers can otherwise demonstrate they have received similar training. This education needs to go beyond safe prescribing of opioids, which many states already require,[xii] so that our nation's healthcare professionals are equipped to respond to our current opioid-related crisis and are prepared to respond to other addiction-related public health threats in the future.

One of the factors that has contributed to the staggering addiction treatment gap we see today is the historical separation of addiction treatment from mainstream medical care. Stigma and misunderstanding about the disease relegated its treatment to the shadows. Physicians and other healthcare professionals in training did not learn how to help prevent, recognize, or treat addiction, because they would not be expected, or paid, to do so in practice.

Additionally, while optional resources and educational opportunities are always welcomed and applauded, they clearly have not been enough. According to a recent survey,[xiii] only 1 in 4 providers had received training on addiction during their medical education. Less than one-third

of surveyed emergency medicine, family medicine, women's health or pediatric providers felt "very prepared" to screen, diagnose, provide brief intervention for, or discuss or provide treatment for, OUD. Perhaps most troubling, less than half of emergency medicine, family medicine and internal medicine providers in that survey believed that OUD is treatable.

Another recent survey of primary care providers (family, internal, and general medicine practitioners) found that a third do not believe that treatment of OUD with medication is more effective than treatment without medication, and more than a third do not believe patients can safely use medication to manage OUD long-term.[xiv] These responses reveal a critical misunderstanding of the substantial evidence for safety and effectiveness of medications for OUD and help explain the persistence of the treatment gap. Training in safe opioid prescribing will not change these misperceptions or help increase use of evidence-based treatment for SUD, including OUD.

The consequences of this history of separating addiction treatment from the rest of medicine have been tragic. From 1999 to 2017, more than 400,000 people in the United States have died from overdoses related to opioids.[xv] The White House Council of Economic Advisers estimates the opioid overdose epidemic cost the United States $696 billion in 2018—or 3.4 percent of GDP—and more than $2.5 trillion for the four-year period from 2015 to 2018.[xvi] And while opioid-related overdose deaths may dominate national headlines, the associated costs are a fraction of the total societal cost of substance misuse and addiction. For example, each year unhealthy drinking leads to approximately 88,000 deaths in America,[xvii] cigarette smoking contributes to another 480,000,[xviii] and overdose deaths related to cocaine and psychostimulant use are on the rise.[xix]

To address this crisis in a comprehensive way, all controlled substances prescribers need to have a basic understanding of addiction and its treatment. No patient population is immune to addiction – the treatment gap shows up among adolescents who experience an overdose but then receive no treatment[xx] and among seniors with an OUD diagnosis but no prescription for medication.[xxi] That is why ASAM supports a requirement for all prescribers of controlled medications to complete training on managing and treating patients with SUD. A synthesis of systematic reviews on the effectiveness of such continuing medical education (CME) is clear: "CME has a positive impact on physician performance and patient health outcomes."[xxii] Thus, requiring prescribers of controlled substances to complete CME training on addiction diagnosis and management can be expected to improve clinician performance and patient health outcomes.

The **Medication Access and Training Expansion (MATE) Act of 2019** would implement such a requirement and would quickly and significantly increase the number of healthcare professionals who can help prevent, recognize, and treat addiction, including the treatment of OUD with buprenorphine, when appropriate. Importantly, the MATE Act would also allow accredited medical schools, residency programs, and schools training physician assistants and advanced practice registered nurses to fulfill the training requirement through comprehensive curriculum that meets the standards laid out in statute, without having to coordinate the development of such education with an outside medical society or state licensing body. This would help normalize addiction medicine education across these professional schools and phase out the need for these future practitioners to take a separate, federally mandated addiction

training course. The MATE Act enjoys strong, bipartisan support, including the support of several sponsors of the MAT Act (discussed below).

3. What factors prevent buprenorphine, from being more widely prescribed to treat opioid use disorder?

Several systemic and cultural factors prevent buprenorphine from being more widely prescribed to OUD. As mentioned above, insufficient healthcare professional training in addiction medicine means clinicians often lack the skills and confidence to treat patients with addiction; it also perpetuates misunderstanding about addiction treatment and stigma toward patients with addiction. The survey of primary care providers noted above revealed that only one-fifth of respondents had an interest in treating patients with addiction and only 11.8% interested in obtaining a waiver to prescribe buprenorphine.[xiv] Increasing clinician understanding of the disease of addiction and effective treatments for it can increase willingness to provide treatment.

Systemic barriers include the separate waiver required to prescribe buprenorphine, which ASAM supports eliminating in conjunction with or after the implementation of a universal training requirement for controlled substances prescribers. Buprenorphine training requirements, X-waiver applications, and DEA audits discourage prescribing buprenorphine.[xxiii] Accordingly, ASAM supports the passage of the **Mainstreaming Addiction Treatment Act,** after or concurrent with passage of the MATE Act, to eliminate what would then be a clearly redundant requirement that practitioners apply for a separate DEA waiver to prescribe buprenorphine for addiction treatment, along with the waiver's patient limits and extra regulatory burdens on buprenorphine.

Finally, insufficient reimbursement from both public and private payers also discourages clinicians from treating patients with buprenorphine. Enforcing health insurance parity requirements and providing financial incentives for clinicians to offer medication treatment for OUD can encourage buprenorphine treatment.

4. A comprehensive report compiled by a committee through the National Academy of Science, Engineering, and Medicine found that buprenorphine is safe to prescribe and is an effective treatment for opioid use disorder. Given that buprenorphine has been proven to be a safe medication, why is it necessary to add additional education not required of other medications?

Buprenorphine is indeed safe to prescribe and an effective treatment for OUD. It should be not be subject to special education requirements, but as a controlled medication, it should be subject (along with all controlled medications) to a one-time, universal training requirement on addiction prevention, diagnosis and treatment that is tied to a DEA controlled substances registration. All controlled substances prescribers have a responsibility to prevent, recognize and treat addiction in their patients and should demonstrate they have completed some training to do so.

The Honorable Lisa Blunt Rochester (D-DE)

1. In 2017, an estimated 46% of Delaware's incarcerated population had substance use issues. Studies show that when the justice-involved population reenters the community, they're at higher risk for relapsing, overdoses, and overdose fatalities. The Delaware Division of Public Health found that 1 in 4 individuals who died from a drug overdose were released from incarceration one year before their death. So, starting this year, Delaware will no longer terminate Medicaid eligibility for incarcerated individuals. Dr. Ryan, can you elaborate on the risks to incarcerated individuals with SUD who aren't connected or transitioned onto support services before their release? How can an upstream investment in transitioning justice-involved individuals help reduce health care costs over time?

Formerly incarcerated individuals are highly vulnerable during the reentry period back into the community. It has been estimated that recently released individuals are roughly 129 times more likely to die of a drug overdose during the first two weeks after release from incarceration compared to the general population.[xxiv] Allowing individuals who are incarcerated to receive services covered by Medicaid up to 30 days prior to their release from incarceration will expand access to vital addiction treatment services. These upstream investments in the health of individuals leaving incarceration can help save health care costs over time through reduced need for emergency services or intervention after relapse or exacerbation of disease. It can also help save criminal justice costs through reduced recidivism; while the factors that lead to recidivism are complex, helping individuals enter and sustain remission from their SUD can help interrupt the cycle of reoffending.[xxv]

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