Medication Assisted Treatment Leadership Council
Statement for the Record

House Energy & Commerce Health Subcommittee Hearing on
An Epidemic Within a Pandemic: Understanding with Substance Use and Misuse in America
April 14, 2021

Chairwoman Eshoo, Ranking Member Guthrie, and members of the Subcommittee, thank you for accepting this statement on behalf of the Medication Assisted Treatment Leadership Council (MAT LC). MAT LC is comprised of nearly 300 Opioid Treatment Program (OTP) facilities and Office-Based Opioid Treatment (OBOT) practices across 40 states, including nearly 40 in California and 11 in Kentucky. Our health care teams provide lifesaving care to more than 100,000 patients suffering from opioid use disorder (OUD) every day.

OTPs are highly-regulated, highly-structured, comprehensive treatment programs that provide Medication-Assisted Treatment (MAT). We are subject to rigorous oversight at the federal, state and local levels – including SAMHSA, the DEA, state regulatory and Medicaid authorities and pharmacy boards. Each of our facilities must be continuously accredited by a SAMHSA-approved body.

OTPs have been the gold standard in treating OUD for the past 50 years. OTPs deliver patient-centered, integrated care under one roof. We employ physicians, pharmacists, nurses, counselors, administrators, social workers, and clerical staff to form interdisciplinary treatment teams that provide daily care to patients suffering from OUD. A patient suffering from OUD has access to the full range of MAT services and medications within the OTP setting, although the vast majority of these patients receive MAT with methadone.

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 testting 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 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 allows 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 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.

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

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 expand business opportunities. Consider that there are currently nearly 97,000 physicians and clinicians waivered to prescribe buprenorphine to more than 6 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. Instead, Congress should seek to ensure that OBOTs, especially those prescribing to a high number of patients, are indeed offering full-service MAT, just like our OBOTs do. Some OBOTs do a great job of providing MAT and a baseline of consistent oversight and regulations would ensure that patients are likely to receive evidence-based treatment in the OBOT setting.

Congress commissioned an HHS study that will include recommendations on where OBOT patient limits should be set. In developing these recommendations, the Secretary is required to examine:

- the average frequency with which qualifying practitioners see their patients;
- the average frequency with which patients receive counseling, including the rates by which such counseling is provided by such a qualifying practitioner directly, or by referral;
- the frequency of toxicology testing, including the average frequency with which random toxicology testing is administered;
- the average monthly patient caseload for each type of qualifying practitioner;
- the treatment retention rates for patients;
- overdose and mortality rates; and
- any available information regarding the diversion of drugs by patients receiving such treatment from such a qualifying practitioner.

The MAT LC firmly believes that Congress should wait to further legislate on the OBOT patient limits before fully considering the findings of the OBOT quality of care report and Secretarial recommendations that it commissioned. That is why **the MAT LC strongly opposes H.R. 1384**, **the *Mainstreaming Addiction Treatment Act of 2021***, which would eliminate any OBOT addiction training requirements and allow OBOT physician and practitioners to treat an unlimited number OUD patients without any oversight from the DEA or SAMHSA. If HHS' report shows that patients are indeed receiving regular counseling, that medication is not being diverted, and that practitioners can appropriately manage 275 patients, then Congress could consider increasing the patient limits above the 175% increase it passed a little over two years ago.

Proponents of H.R. 1384 argue that patient limits do not exist for other diseases. This is true. But consider that OUD patients are extremely complex patients that should be treated by professionals trained in addiction medicine. Nine of the 11 diagnostic criteria for opioid use disorder are behavioral components, just two are physiological (Diagnostic and Statistical Manual of Mental Disorders-V). Would you trust a podiatrist to treat cancer? Would you want a dentist to perform heart surgery? Physicians and surgeons specialize in areas of medicine for a reason. A baseline level of training in treatment OUD should be required.

Proponents of H.R. 1384 will also note that some foreign countries, like France, do not impose limits on the number of patients receiving buprenorphine. In France, patients can only receive up to seven days of buprenorphine before returning the physician for another prescription. Physicians in France usually request that pharmacists provide daily, supervised dosing of buprenorphine.[2] In the U.S., patients can go up to six months without seeing their physician and still receive refills for their buprenorphine prescription every month. Buprenorphine diversion is also a significant problem in France. "Diversion (i.e., selling or giving away medication) of buprenorphine to the illicit market is also a major concern and has contributed to an extensive black market in some European countries."

Buprenorphine diversion is already an issue in the U.S. as well. In fact, a recent Johns Hopkins study found that "approximately 43% [of those receiving buprenorphine] filled an opioid prescription during the treatment episode and 67% filled at least one prescription opioid following their treatment episode."[3]

The MAT LC supports H.R. 2379, the ***State Opioid Response Grant Reauthorization Act***, with important modifications. While we support the new funding associated with this legislation, we would like to see a portion of this money earmarked specifically for MAT in the OTP and OBOT settings so that the money is actually reaching patients. Such funding could be used to offset the cost of treatment for those who are unable to pay, to hire and train new mental health professionals, etc.

Additionally, we would like the Committee to consider amending the State Opioid Response grant program to ensure that all OTPs have access to this stream of federal funding. This epidemic requires an "all qualified hands on deck" approach. Given the track record of patient outcomes and robust regulatory and oversight structures associated with OTPs, Congress can be comfortable knowing this money will be spent efficiently and focused on what most important – patients suffering from OUD.

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[2] Buprenorphine substitution treatment in France: drug users' views of the doctor-user relationship, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1950347/

[3] http://www.jhsph.edu/news/news-releases/2017/many-patients-receive-prescription-opioids-during-medication-assisted-treatment-for-opioid-addiction.html

The MAT LC also supports H.R. 2067, the *Medication Access and Training Expansion Act*. We agree that providers would benefit from additional training in addiction medicine, particularly those who seek to administer MAT to patients suffering from OUD. However, this baseline training should not be considered a replacement for oversight and regulation or a green light to treat an unlimited number of patients. This bills should be seen as being complimentary of the current X-waiver.

In order to combat the opioid abuse epidemic, the MAT LC urges Congress to make permanent a provision in the SUPPORT Act which requires state Medicaid programs to cover all FDA-approved medication to treat OUD. We also suggest removing tax-status limitations through the Substance Abuse Block Grant and specifically earmarking funds derived from opioid settlements for treatment purposes, including those provided in the OTP setting. Lastly, there is much Congress could do to encourage greater collaboration between providers involved in treating OUD, including funding for programs like Vermont's "hub and spoke" model which connects physician practices (spokes) with OTPs (hubs) to help manage patient care and offer expertise.

Thank you for considering our comments today. The MAT LC looks forward to working with the Committee as it seeks to move legislation to combat this deadly disease.

Sincerely,

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