May 9, 2018

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
2332A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden and Ranking Member Pallone,

On behalf of the American Society of Addiction Medicine (ASAM), the nation's oldest and largest medical specialty society representing professionals who specialize in the prevention and treatment of addiction, and now with more than 5,000 physician and allied health professional members, I am writing to offer our comments and recommendations on legislation being considered before your Committee to address the opioid misuse, addiction, and overdose epidemic.

The cost of substance misuse, and untreated and ineffectively treated addiction in the United States is staggering, both in economic terms and in terms of human lives lost. During the twelve-month period ending January 2017, the Centers for Disease Control and Prevention (CDC) estimates there were approximately 64,000 drug overdose deaths.[1] Recently, the White House Council of Economic Advisers announced that the cost of the opioid crisis, alone, approached $504 billion in 2015.[2] 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. Each year unhealthy drinking leads to approximately 88,000 deaths in America.[3] Cigarette smoking contributes to another 480,000.[4] These costs, however, could be dramatically reduced by utilizing effective and evidence-based substance misuse prevention practices and programs and by addressing untreated, and ineffectively treated addiction in this country.

We applaud the Committee for dedicating so much time and resources to addressing the opioid misuse, addiction, and overdose epidemic. Turning the tide on the current crisis and preventing future crises related to substance misuse and addiction require a new approach to the delivery of substance use prevention, addiction treatment, and recovery support services. Considering all the lives we have lost and all the lives we still risk losing, the time for transformational change is now.

While we recognize that there are many worthwhile proposals pertaining to the opioid misuse, addiction, and overdose epidemic before the Committee, ASAM believes that to address this national crisis, Congress

11400 Rockville Pike, Suite 200, Rockville, MD 20852
Phone: 301.656.3920 | Fax: 301.656.3815
www.ASAM.org

must pass legislation that 1) ensures the provision of treatment that is consistent with evidence-based standards, 2) grows the addiction treatment workforce, and 3) expands access to quality addiction treatment.

As such, we respectfully offer our strong support for the following bills which we feel are among the most important currently under consideration by your committee for reducing the rates of overdoses and deaths. We ask that the Committee consider and approve:

1. **Ensuring the provision of evidence-based addiction treatment**
    a. *Reinforcing Evidence-Based Standards Under Law in Treating Substance Abuse* (RESULTS) Act (H.R. 5272), as introduced;
    b. Section 3434 of the *Comprehensive Addiction Resources Emergency Act of 2018* (H.R. 5545);
    c. *Limited repeal of the IMD Medicaid exclusion for adult Medicaid beneficiaries with substance use disorder* (Discussion Draft), incorporating ASAM's recommendations further described below; and
    d. *Opioid Prevention and Patient Safety Act* (H.R. 3545).
2. **Expanding the addiction treatment workforce**
    a. *Addiction Treatment Access Improvement Act* (H.R. 3692);
    b. *Enhancing Access to Addiction Treatment Act of 2018* (S. 2711); and
    c. *Substance Use Disorder Workforce Loan Repayment Act* (H.R. 5102) and the inclusion of "addiction medicine specialists" in the definition of "behavioral and mental health professionals" within the National Health Service Corps.
3. **Expanding access to quality addiction treatment**
    a. *Medicaid Reentry Act* (H.R. 4005); and
    b. *Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act* (H.R. 5605).

Ensuring the provision of evidence-based addiction treatment

There are many misconceptions about the disease of addiction, and a culture change is needed in this country to drive patients to the treatment options that have been proven to be effective at reducing overdose deaths and supporting patients in remission and recovery.

When it comes to addiction involving opioid use, the most effective treatment options involve the use of medications in combination with specific, psychosocial interventions to support remission and recovery and involve a certified addiction medicine specialist in the patient's care. When we say, "Treatment works," we are not referring to every approach that claims to be treatment. Rather, as physicians and other clinicians who specialize in the treatment of addiction, we are specifically referring to those interventions that have scientific evidence to support their effectiveness. As such, we ask the Committee to consider and approve:

The Reinforcing Evidence-Based Standards Under Law in Treating Substance Abuse (RESULTS) Act (H.R. 5272).

As introduced, the legislation would require grant, loan, and other recipients of funds from the Department of Health and Human Services (HHS) for a mental health or substance use disorder prevention or treatment program to use evidence-based practices.

ASAM believes recipients of federal grants, loans and other funds for mental health or substance use disorder prevention or treatment programs should use evidence-based practices to the greatest extent possible. The RESULTS Act as introduced would raise the clinical standard to a level that we demand from all other forms of medicine—the use of clinical methods and practices based on evidence. As the full Committee considers this legislation, we hope the Subcommittee-reported language will be strengthened to reflect more closely the bill as introduced, which included stronger requirements to ensure that recipients of federal funds use evidence-based practices.

Section 3434 of the Comprehensive Addiction Resources Emergency Act of 2018 (H.R. 5545)

This section of legislation would require HHS, in consultation with ASAM, to develop and disseminate model standards for the regulation of substance use disorder treatment services. While there has been much discussion about the need to improve the regulation of sober homes, developing evidence-based regulations for treatment programs has been largely absent from those discussions. However, we know well that as the field of addiction treatment works to integrate more fully with traditional medical care, it is imperative that it "catch up" with other medical specialties. Federal efforts that are designed to promote high-quality addiction treatment are critically needed to help improve the overall quality of addiction treatment provided in our nation and assure those who are seeking and paying for treatment that they are receiving medically appropriate and high-quality care. Expert-driven development of model standards for the regulation of substance use disorder treatment services would be a much-needed step in the right direction.

Limited repeal of the IMD Medicaid exclusion for adult Medicaid beneficiaries with substance use disorder (Discussion Draft), further modified to incorporate the following ASAM recommendations:

ASAM supports a partial repeal of the IMD exclusion for those residential treatment programs that can deliver services consistent with The ASAM Criteria or other nationally-recognized and evidence-based criteria and provide evidence-based substance use disorder treatment, including FDA-approved agonist (or partial agonist) and antagonist medications for treatment of opioid use disorders. Any legislation should ensure that treatment provider assessments for all addiction treatment services, levels of care, and length-of-stay recommendations, as well as methods of residential treatment program qualification, are verified by an independent third party that has the necessary competencies to use The ASAM Criteria or such other evidence-based patient placement assessment tools and nationally-recognized program standards, as applicable.

While it is possible that individual clinicians might be able to make accurate determinations about patient placement and treatment duration according to The ASAM Criteria, and states might be able to develop various methods of residential treatment provider qualification, without verification through a third party that has the necessary competencies to use The ASAM Criteria (or such other nationally-recognized and evidence-based patient placement assessment criteria and program standards, as applicable), public and private payers do not know if clinicians and residential treatment programs are reliably and accurately utilizing evidence-based criteria with fidelity to those criteria. Transforming our national addiction treatment infrastructure requires a policy and care delivery framework that facilitates full and correct implementation of nationally-recognized and evidence-based criteria ensuring high-quality addiction treatment for those who need it. Thus, ASAM strongly urges the Committee to adopt these recommended changes.

Opioid Prevention and Patient Safety Act (H.R. 3545)

This legislation would align 42 CFR Part 2 (Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of health care treatment, payment, and operations

(TPO). It would also strengthen protections against the use of substance use disorder records in criminal proceedings. A subsequent draft bill would further incorporate additional protections.

The federal regulations governing the confidentiality of drug and alcohol treatment and prevention records, 42 CFR Part 2 (Part 2), set requirements limiting the use and disclosure of patients' substance use records from certain substance use treatment programs. Obtaining multiple consents from the patient is challenging and creates barriers to whole-person, integrated approaches to care, which are part of our current health care framework. For example, Part 2 regulations may lead to a physician treating a patient and writing prescriptions for opioid pain medication for that individual without knowing the person has a substance use disorder.

Further, separation of a patient's addiction record from the rest of that person's medical record creates several problems and hinders patients from receiving safe, effective, high-quality substance use treatment and coordinated care. The advent of integrated health systems and electronic medical records has improved the safety, quality, and coordination of care for patients with any other health condition. Part 2 requirements prevent patients with addiction from sharing in these benefits, even though electronic exchanges of other health information are governed by strict privacy and security standards set by the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Thus, we support changes that would align Part 2 with HIPAA's consent requirements for the purposes of *treatment*, *payment*, *and healthcare operations*. Such a change would allow for the sharing of patients' addiction treatment records within the healthcare system under HIPAA's well-established and modern privacy and security protections, while leaving in place Part 2's prohibition on disclosure of records outside the healthcare system. Moreover, we also welcome changes that would strengthen protections against the inappropriate use of addiction treatment records, a further improvement to Part 2 that we see as essential to protect patients in treatment for substance use disorder.

In sum, the enactment of H.R. 5272, as introduced; Section 3434 of H.R. 5545; the limited repeal of the IMD Medicaid exclusions (incorporating ASAM's recommendations described above), and H.R. 3545 would be historic steps toward a day when our nation's addiction treatment infrastructure can consistently deliver affordable, evidence-based, and comprehensive addiction treatment to those in need.

Expanding the Addiction Treatment Workforce

The current addiction treatment gap will never be closed with the current addiction treatment workforce. There are simply too few physicians and other clinicians with the requisite knowledge and skills to meet the needs of the estimated 20.1 million Americans suffering from untreated substance use disorder. To make a meaningful and sustainable impact on the current opioid misuse, addiction, and overdose epidemic, and to stave off future epidemics related to other addictive substances such as cocaine, benzodiazepines or methamphetamine, it is imperative that our country make strategic investments to incentivize clinicians to work in programs and practices that specialize in the treatment of substance use disorder and addiction.

We ask the Committee to promptly approve the following bills to grow the addiction treatment workforce:

Addiction Treatment Access Improvement Act (H.R. 3692)

The bill: 1) eliminates the sunset date for nurse practitioners' (NPs) and physician assistants' (PAs) prescribing authority for buprenorphine, 2) codifies the final rule issued by the Department of Health and Human Services (HHS) in July 2016 that raised the DATA 2000 patient limit for only

certain physicians to 275 patients and 3) expands the definition of "qualifying practitioner" to include nurse anesthetists, clinical nurse specialists, and nurse midwives.

Codifying the recent gains in improved access to addiction treatment provided by physicians and other prescribers and ending arbitrary time limits on those treating patients with opioid use disorder will ensure that these individuals will continue to have access for evidence-based care. Although physicians are providing more addiction treatment than ever before, expanding the addiction treatment workforce to include all advance practice registered nurses is urgently needed to address access challenges and provider shortages due to the magnitude of this epidemic.

Enhancing Access to Addiction Treatment Act of 2018 (S. 2711)

This bill would create a new, voluntary training pathway for physicians to receive a waiver to treat patients with opioid addiction with evidence-based medications and would establish a new grant program to support accredited schools of allopathic medicine or osteopathic medicine that develop curricula on addiction medicine, which may include pain management, which meet the requirements of said legislation.

By establishing this additional pathway to obtain a DATA waiver, not only will physicians be able to satisfy the waiver training requirement by taking approved courses during medical school, but the number of graduates who will enter the practice of medicine with an educational background that includes addiction medicine will be increased.

Substance Use Disorder Workforce Loan Repayment Act (H.R. 5102) and the explicit inclusion of "addiction medicine specialists" in the definition of "behavioral and mental health professionals" within the National Health Service Corps

To incentivize clinicians to work in substance use disorder treatment programs to grow the addiction medicine workforce, particularly in high-need areas, we support the following:

- Full Committee consideration and passage of the *Substance Use Disorder Workforce Loan Repayment Act* (H.R. 5102) to help clinicians who pursue full-time substance use disorder treatment jobs in high-need geographic areas repay their student loans; and
- Inclusion of addiction medicine specialists in the definition of "behavioral and mental health professionals" within the National Health Service Corps. Unfortunately, the definition of "behavioral health and mental health" in the Public Health Service Act does not necessarily extend to addiction, in fact, addiction may be excluded in some instances. We ask that this Committee update the definition to ensure that addiction medicine specialists are included in the definition.

Expanding Access to Addiction Treatment

Medicaid Reentry Act (H.R. 4005)

The risk of opioid-related overdose death dramatically increases in the first days and weeks after an individual with untreated opioid use disorder is released from jail or prison.

Providing treatment access during incarceration and warm handoffs to community-based care upon release can reduce this risk and help save lives. Passing legislation to facilitate pre-release treatment and connections to community-based care for individuals released from the criminal justice system should be a key part of a comprehensive Congressional response to the ongoing opioid misuse, addiction, and overdose epidemic.

The Medicaid Reentry Act addresses this need directly by granting states limited new flexibility to restart benefits for Medicaid-eligible incarcerated individuals 30 days prior to release. With this flexibility, states would be able to facilitate access to medication and other treatment for inmates prior to release and better coordinate care with community providers, allowing for uninterrupted, evidence-based treatment for these individuals during a transition when they are at heightened risk of overdose and death. This legislation would not expand Medicaid eligibility.

Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act (H.R. 5605)

In 2016, approximately one third of Medicare beneficiaries received an opioid prescription and over half a million received high doses of opioids yet many lack access to quality substance use disorder treatment.[56] This legislation reported by the Health Subcommittee would create an Alternative Payment Model (APM) demonstration program to incent the delivery of high quality, evidence-based substance use disorder treatment services. The voluntary program would enroll eligible beneficiaries who agree to receive SUD treatment services through providers and institutions participating in the program.

APM demo program participants would receive both medication and psychosocial supports, such as care management, psychotherapy, treatment planning and appropriate social services to treat substance use disorder. Care teams would require inclusion of health care providers who are licensed to dispense opioid medications for detoxification or maintenance treatment for opioid use disorder, as well as appropriate providers of psychosocial treatment.

ASAM providers continue to see instances where patients cannot access the care they need due to insufficient insurance coverage of comprehensive treatment. We know that medication with attention to psychosocial needs is the evidence-based standard for treating addiction involving opioid use. The introduction of this bill acknowledges this and is a great step in the right direction. We urge the full Committee to approve this important legislation.

Conclusion

Thank you for the opportunity to make recommendations and offer additional tools that may be helpful to combat this public health emergency. We thank you again for the work thus far on legislative solutions to the opioid misuse, addiction, and overdose epidemic, and we look forward to working with you as the legislative process moves forward. If you have any questions or concerns, please contact Kelly Corredor, ASAM's Director of Advocacy and Government Relations, at kcorredor@asam.org or at 301-547-4111.

Sincerely,

Kelly J. Clark, MD, MBA, DFASAM
President, American Society of Addiction Medicine

CC:

The Honorable Michael Burgess
The Honorable Gene Green

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[1] Provisional Counts of Drug Overdose Deaths, as of 8/6/2017; https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf

[2] The Council of Economic Advisers. November 2017. "The Underestimated Cost of the Opioid Crisis" https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf.

[3] Stahre, M., Roeber, J., Kanny, D., Brewer , R. D., & Zhang, X. (2014). Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. *Preventing Chronic Disease*, *11*(E109).

[4] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2017 Nov 29].

[5] An average morphine equivalent dose (MED) greater than 120mg per day for at least 3 months.

[6] U.S. Department of Health & Human Services, Office of Inspector General. Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing. HHS OIG Data Brief. (Jul 2017) (https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf)