March 17, 2023

The Honorable Bernie Sanders
Chair, U.S. Senate Committee on Health, Environment, Labor, and Pensions (HELP)
332 Dirksen Senate Office Building
Washington, DC, 20510

The Honorable Robert Cassidy
Ranking Member, U.S. Senate Committee on Health, Environment, Labor, and Pensions (HELP)
455 Dirksen Senate Office Building
Washington, DC, 20510

Dear Chair Sanders and Ranking Member Cassidy:

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 7,000 physicians and other clinicians who specialize in the prevention and treatment of addiction and co-occurring conditions, thank you for inviting stakeholders to respond to your request for input on solutions to the nation's health care workforce shortage. As you know, there is no one solution to this problem, but many. This letter describes three of them, which are specific to addressing the addiction workforce shortage and relevant to your committee's jurisdiction. ASAM greatly appreciates your leadership on these matters.

Reauthorize the Substance Use Disorder (SUD) Treatment and Recovery (STAR) Loan Repayment Program and Preserve its Focus on SUD

There are not enough physicians and other clinicians with the requisite knowledge and training to meet the needs of the millions of Americans suffering with SUD. According to the Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Survey of

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

Drug Use and Health, in 2021, more than 44 million Americans over the age of 18 had SUD in the past year.[1] Notably, more than 24 million of them had SUD and no co-occurring mental illness.[2] According to the Centers for Disease Control and Injury Prevention, deaths continue at record levels from drug overdoses.[3] Both the Health Resources and Services Administration (HRSA) and SAMHSA have recognized that there is insufficient access to SUD treatment providers.[4]

The SUD workforce shortage causes some individuals to be forced to wait weeks, or even months, to receive life-saving treatment, and the shortage represents a barrier to the full integration of physical health care and SUD treatment services. In fact, only 18% of individuals with opioid use disorder (OUD) receive evidence-based treatment, and the lack of providers has been cited as the leading reason.[5] Compounding the problem is the reality that many mental health professionals, including many psychiatrists, fail to diagnose or treat SUD.[6]

Congress has acknowledged the severity of the SUD workforce shortage by authorizing a groundbreaking loan repayment program in the SUPPORT for Patients and Communities Act, which is exclusive to the SUD workforce. It was first funded in Fiscal Year 2020. The program helps individuals who pursue full-time SUD treatment jobs in high-need geographic areas repay their student loans. Demand has been overwhelming. In FY21, 3,184 people applied for the program, but HRSA only had enough funding to serve 8% or 255 of them, at an average award amount ($103,603) that was less than half of the maximum allowed ($250,000).

Expanding loan repayment opportunities exclusively dedicated to SUD treatment professionals by reauthorizing the STAR-LRP, at a minimum level of $50 million for each fiscal year,[7] will significantly help increase the number of dedicated and well-trained SUD treatment providers in high-need communities. In the absence of a stronger SUD workforce, far too many patients seeking recovery from addiction will continue to face insufficient access to providers, denials for treatment services, and long wait lists.

Pass S. 644- the Modernizing Opioid Treatment Access Act (the "M-OTAA")

The importance of expanding an addiction specialty workforce that can legally provide methadone treatment for OUD in the U.S. cannot be overstated. The Food and Drug Administration has only approved three medications to treat OUD: buprenorphine, naltrexone, and methadone.[8] Methadone, a synthetic, long-lasting opioid agonist, is a gold standard medical treatment for OUD. OUD is associated with a 20-fold greater risk of early death due to overdose, infectious disease, trauma, and suicide.[9] Methadone is the most well-studied pharmacotherapy for OUD, and the one with the longest track record.[10]

Methadone is safe and effective for patients when indicated, dispensed, and consumed properly.[11] Treatment with methadone brings stability for patients with OUD by mitigating the "lows" of painful withdrawal, and attenuating the euphoric "highs" of shorter-acting opioids, such as fentanyl.[12] In so doing, methadone assists patients with OUD with remission and recovery and allows them to function well in daily life. In addition, methadone treatment for OUD is associated with reduced overdose mortality.[13]

Restrictions that limit the current addiction specialty workforce's ability to deliver methadone treatment for OUD, however, are a well-recognized handicap in the response to the overdose

crisis.[14] Current federal law and regulations limit its availability to heavily regulated opioid treatment programs (OTPs) in an infrastructure that has significant implications for patients' access to and quality of care. Moreover, there are less than 2,000 OTPs[15] and over 61,000 community pharmacies in the U.S.,[16] approximately one OTP for every 32 pharmacies. More than ninety percent of OTPs are in urban areas,[17] and most U.S. counties have no OTPs,[18] which significantly impacts who has access to methadone treatment for OUD.

Further, many patients have a negative perception that often based on their lived experience that methadone treatment at OTPs is like "liquid handcuffs," and this deters patients' engagement with treatment and recovery.[19] The restrictions on methadone treatment for OUD have created unequal and segregated access to medications for OUD. People of color with OUD are less likely to receive medications for OUD, while White people with OUD are more likely to receive treatment with buprenorphine, which can be prescribed in office-based settings.[20][21][22] The restrictions on methadone treatment for OUD have been contributing to alarming trends of inequities in worsening overdose mortality rates, particularly for Black Americans and other people of color—trends that were accelerated during the COVID-19 pandemic.

Congress must modernize the delivery of methadone treatment for OUD to address the deadly role of fentanyl in driving the rise of, and increased disparities in overdose deaths.[23] Specifically, federal law must be modernized - law that predates the establishment of addiction medicine and addiction psychiatry as medical subspecialities recognized by the American Board of Medical Specialties.[24] This is urgently needed to expand access to cost-effective methadone treatment for OUD in the U.S. Doctors who hold such board certification are some of the foremost experts in the comprehensive treatment of people with addiction.

Responsible measures to expand access to methadone treatment for OUD in medical settings and areas in the U.S. where it is not available now[25] are critical to save lives, help families, and strengthen the addiction workforce and the communities they serve. To this end, the M-OTAA would authorize the DEA to issue special registrations for OTP clinicians and addiction specialist physicians who could then use their clinical expertise in prescribing methadone for OUD treatment that could be picked up at pharmacies, subject to SAMHSA rules/guidance on supply of methadone for unsupervised use. While the M-OTAA would help to integrate methadone treatment for OUD with the rest of general health care, it would not mean methadone for anyone, prescribed by anyone. It would simply create an additional pathway for appropriately prescribed methadone treatment for OUD managed by addiction specialist physicians and OTP prescribing clinicians.

Although methadone-related overdose deaths are also an unfortunate reality, science informs that the lethality of the medication does not depend on the physical place from where it is dispensed, but on the skill of the prescriber, the diagnosis for which it is being prescribed, and the stability of the patient. Addiction specialist physicians and OTP clinicians are uniquely situated to make a proper risk-benefit evaluation when it comes to prescribing methadone for OUD and to manage any diversion risk. Furthermore, the contemporary lethality of utmost concern is an untreated demand for an illegal drug supply adulterated with fentanyl, which the M-OTAA can help address. Indeed, the failure of methadone treatment to meet the capacity needs of Americans with OUD has come with high financial, societal, and human costs, during a

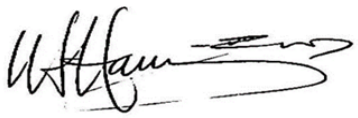
long-declared opioid public health emergency.[26] The M-OTAA is a measured, but critical workforce down payment that cannot be made soon enough.

Pass Legislation Codifying a New Telehealth Evaluation Exception to the Ryan Haight Act for Addiction Medications

ASAM is deeply committed to ensuring every person with SUD has access to high-quality, full-spectrum addiction care and to closing the addiction treatment gap.[27] This commitment includes advocating for optimizing telehealth access and utilizing it to advance health equity in addiction medicine. With the illicit drug supply becoming increasingly lethal,[28] and the COVID-19 pandemic's exacerbation of challenges faced by people with SUD,[29] racial and ethnic health disparities have widened with record numbers of drug overdose deaths.[30] Although telehealth for addiction care grew more slowly than it did for other types of medical care before the onset of COVID-19,[31] the pandemic catalyzed sweeping changes that brought telehealth and addiction care beyond where it was previously underutilized or prohibited.

The emergency administrative actions of the DEA during the COVID-19 public health emergency (PHE), which allowed for greater flexibilities in the treatment of OUD via telemedicine, have been critical tools for expanding access to OUD treatment and enhancing the reach of the existing addiction workforce. Unfortunately, those COVID PHE telemedicine flexibilities are now in jeopardy of expiring on May 11 due to the anticipated expiration of the COVID PHE. Furthermore, the DEA's recently announced proposed rules for telemedicine prescribing fail to preserve those flexibilities in full after May 11, which may result in the loss of appropriate clinical access to buprenorphine for OUD. Thus, ASAM urges your committee to consider passage of federal legislation that would establish a new, audio-video, telehealth evaluation exception to the Ryan Haight Act's in-person exam requirement, solely for the purposes of prescribing controlled medications approved, and used, for the treatment of addiction. Swift passage of such legislation is critical to enhancing the reach of the nation's addiction workforce.

Sincerely,



William F. Haning, III, MD, DLFAPA, DFASAM
President, American Society of Addiction Medicine

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