American Society of Addiction Medicine
11400 Rockville Pike #200
Rockville, Maryland 20852

Written Statement for the Record

Closing Gaps in the Care Continuum: Opportunities to Improve Substance Use Disorder Care in the Federal Health Programs

Submitted to the U.S. Senate Committee on Finance, Subcommittee on Health Care

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The American Society of Addiction Medicine (ASAM) is a national medical society representing over 7,000 physicians and other clinicians dedicated to preventing and treating addiction and co-occurring conditions. ASAM commends the Subcommittee for convening a recent roundtable on enhancing substance use disorder (SUD) care in federal health programs and appreciates the opportunity to provide this written statement for the record.

Today, no American community remains untouched by the unprecedented crisis of substance use, addiction, and associated death. As alcohol,[1] synthetic opioids such as fentanyl, psychostimulants like methamphetamine, and other substances including xylazine, sedative-hypnotics, nicotine, and inhalants, contribute to elevated death rates and medical complications, there is an urgent need to establish a sustainable and robust SUD care infrastructure that recognizes addiction as a preventable and treatable chronic medical condition.

To address these challenges effectively, ASAM recommends prioritization of the following key strategies:

1. Strengthening the Addiction Specialist Physician[2] Workforce;
2. Establishing Universal Access to Addiction Medications as Standard of Care; and
3. Ensuring Appropriate Coverage Of, and Reimbursement For, Effective Addiction Care.

By acting on these strategies, the Subcommittee can make significant strides in improving SUD care delivery in federal health programs and mitigating the devastating impact of SUD nationwide.

Strengthening the Addiction Specialist Physician Workforce

Addiction is a chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.[3] In 2022, almost 49 million Americans had a SUD in the past year,[4] contributing to high levels of drug overdose deaths.[5] A persistent challenge lies in the medical community's lack of understanding and misinformation about addiction.

Insufficient numbers of physicians who specialize in the diagnosis and assessment of SUD and the prevention and treatment of the disease of addiction is of grave concern. Only 102 Accreditation Council for Graduate Medical Education (ACGME)-accredited addiction medicine fellowship programs exist nationwide,[6] falling short of the goal of 125 fellowships by 2022 set by the President's Commission on Combating Drug Abuse and the Opioid Epidemic in 2017.[7] These fellowships, available to a wide range of physicians, including those in family medicine, internal medicine, psychiatry, pediatrics, and emergency medicine, offer vital training in evidence-based SUD care.

To address the shortage of addiction specialist physicians in the U.S., the Stanford-Lancet Commission on the North American Opioid Crisis has recommended expanding the number of such fellowships.[8] **Similarly, ASAM advocates for passage of H.R. 7050 - the Substance Use Disorder Workforce Act of 2024, with a recommendation that the Senate include additional monetary incentives in the bill for physicians training as addiction specialists.** Currently, this bipartisan legislation would provide Medicare support for an additional 1,000 graduate medical education positions over five years in hospitals with accredited fellowships in addiction medicine, addiction psychiatry, or pain medicine and their prerequisite programs.

Further, to increase the numbers of medical clinicians willing to treat Medicare beneficiaries with SUD, the Subcommittee should consider **legislation that would provide annual, Medicare Economic Index updates to reimbursement levels for the Medicare Office-Based SUD Bundled Payment,[9] modeled after the annual updates for the Medicare OTP Bundled Payment in the SUPPORT Act of 2018**. Research indicates that this approach enhanced the uptake of the OTP benefit among Medicare beneficiaries.[10]

<u>Establishing Universal Access to Addiction Medications as Standard of Care</u>

Although the regulation of methadone treatment for opioid use disorder (OUD) does not fall within the Subcommittee's jurisdiction, the topic was discussed extensively at the roundtable. Most patients primarily using opioids at admission to publicly funded SUD treatment do not receive medication treatment for OUD.[11] While integrated methadone treatment models exist in the U.S., they are more common internationally. A 2017 international meta-analysis demonstrated a significant reduction in all-cause mortality among individuals treated with methadone for OUD, both in general practice and specialty clinics.[12,13] Randomized controlled trials have demonstrated the safety and efficacy of methadone treatment in primary care of stable patients,[14,15] supported by long-term safety data from non-randomized studies.[16,17,18] Methadone has been prescribed for OUD in Australia since 1970 and in Great Britain since 1968.[19]

In the U.S., the Food and Drug Administration (FDA) determined and approved methadone as safe and effective for treatment of OUD in 1972.[20] However, erroneous beliefs that methadone replaced one addiction for another, reports of methadone-related deaths and diversion,[21] and concerns over increasing crime rates[22] created a climate of skepticism, hostility, and outright stigma toward methadone-based OUD care. In 1974, Congress granted additional authority over methadone to the DEA.[23] Both FDA, and subsequently the Substance Abuse and Mental Health Services Administration (SAMHSA), replaced the usual practice of physician autonomy with strict rules governing the provision of methadone for OUD treatment that do not apply when methadone is prescribed for pain and dispensed from a community pharmacy.

Federal regulations restrict methadone treatment to a closed system of regulated clinics, known as opioid treatment programs (OTPs).[24] Despite recent updates to OTP regulations,[25] access to methadone treatment for OUD remains limited to primarily OTPs, notwithstanding increased OUD prevalence.[26] A sizable majority of U.S. counties lack OTPs,[27] and existing OTPs have limited geographic reach,[28] which, among other drawbacks, may unnecessarily increase the use of greater take-home methadone supplies.

S. 644 – the Modernizing Opioid Treatment Access Act (MOTAA), supported by ASAM and over 100 other organizations,[29] aims to expand access to methadone treatment for OUD by allowing addiction specialist physicians — representing some of the most educated and experienced physicians using pharmacotherapies for OUD in the nation[30] - to prescribe methadone for OUD that can be dispensed from a community pharmacy. While diversion fears have been stoked by MOTAA's opponents, Subcommittee members are encouraged to remember the following:

- Several factors contributing to an increase in methadone-associated deaths when the medication was prescribed for pain management in the late 1990s/early 2000s have been well-documented;[31] appropriately addressed (e.g., methadone for pain is still available in U.S. pharmacies today), and are not applicable in the context of MOTAA and methadone for the treatment of OUD;
- Methadone diversion that does occur is associated with a lack of medical access to the medication;[32]
- Among people using illicit methadone, the most common reason is a missed medication pick-up;[33] and
- When finalizing current take-home methadone flexibilities in its Part 8 rule governing OTPs, SAMHSA states as follows: "In a national meeting, State authorities reported that the flexibilities were appreciated by patients and OTPs alike, with no significant change in rates of diversion seen since the COVID–19 PHE was declared. Indeed, analysis of the relevant data indicates that the actual level of misuse, diversion or harm from methadone is more likely to occur when it is prescribed for pain as opposed to OUD, and that the rate of diversion is lower than that of oxycodone or hydrocodone. Additionally, a survey found that diversion of methadone is low among patients receiving take-home doses under the COVID–19 PHE flexibility. Further to this, analysis of data on fatal overdoses from January 2019 to August 2021 demonstrated that this flexibility did not lead to more deaths involving methadone."[34]

Finally, among other safeguards contained in MOTAA, the separately registered, expert prescribers would remain subject to SAMHSA's continued regulation and guidance on quantities of methadone for unsupervised use. In short, MOTAA represents a responsible expansion in methadone access for OUD through a highly trained, modern-day workforce of expert physicians who can safely manage this essential treatment for Americans who need it.

<u>Ensuring Appropriate Coverage Of, and Reimbursement For, Effective Addiction Care</u>

Closing Medicare's Coverage Gap for Residential SUD Services

Medicare covers approximately 65.7 million older Americans and those with certain disabilities.[35] However, its coverage for SUD services is outdated. As noted in Dr. Brendan Saloner's remarks

at the roundtable, Medicare does not cover non-hospital-based residential addiction treatment programs. This creates a deadly coverage gap for some among the 1.7 million Medicare beneficiaries with SUD.[36] To the extent these Medicare beneficiaries require 24-hour addiction care in the context of a safe and stable living environment, they largely do not have affordable access to the medically necessary setting that best meets their needs.

In October 2023, ASAM released the Adult Volume of *The ASAM Criteria*, Fourth Edition.[37] This edition describes essential standards for residential addiction treatment programs, aiming to connect patients with the right level of care and enhance payers' understanding of the medical capacity of residential addiction treatment programs nationwide. These standards can improve the quality of residential care, as they include an expectation that all medically managed residential programs (i.e., Level 3.7) can initiate addiction medications. Less intensive residential levels of care (i.e., Levels 3.1 and 3.5) must be able to support the continuation of all addiction medications. These updated program standards are critical to ensuring that more Americans, including Medicare enrollees, receive evidence-based medications to treat their SUD, including OUD.[38]

Thus, ASAM urges the Subcommittee to consider **supporting federal legislation that would create a new Medicare Part A benefit for residential addiction treatment programs (i.e., ASAM Level 3) meeting nationally recognized standards**. Eligible programs should be required to offer a planned and structured regimen of twenty-four-hour care. Specifically, the new benefit should cover the following adult patient programs: Level 3.1: Clinically Managed Low-intensity Residential Treatment; Level 3.5: Clinically Managed High-intensity Residential Treatment, and Level 3.7: Medically Managed Residential Treatment. Additionally, the legislation should establish a new prospective payment system, ensuring that reimbursement for covered residential addiction treatment services is based on a predetermined, fixed amount.

Amending the Medicaid Inmate Exclusion Policy

Individuals who are incarcerated have high rates of chronic diseases, including substance use and mental health disorders, and typically have low incomes, making many Medicaid-eligible.[39] However, the current healthcare payment system is inadequate for effectively treating people with SUD who are incarcerated. Reforming payment policies for health care for substance use and mental health treatment among people who are incarcerated is crucial for expanding access to evidence-based care and saving lives.

The Medicaid Inmate Exclusion Policy (MIEP) in federal law severely restricts Medicaid from paying for healthcare services for individuals who are incarcerated, including pretrial detainees. Approximately 65% of individuals who are incarcerated in jails in the U.S., an estimated 490,000 people, were awaiting court action in 2019.[40] Research shows that within the first two weeks after release, individuals who are incarcerated are 129 times more likely to die from overdose, particularly opioid-related, compared to the general U.S. population.[41] Healthcare coverage during incarceration significantly affects the lives of Americans with SUD, and Medicaid coverage for those who are incarcerated can prevent overdose deaths.

Therefore, ASAM supports the passage of the following legislative measures: (1) **S. 971 - the Due Process Continuity of Care Act**, which would amend the MIEP to allow otherwise eligible adults receive their full Medicaid benefits while incarcerated and awaiting trial at the option of the state

and (2) **S. 1165- the Reentry Act of 2023**, which would allow states to restart Medicaid coverage for Medicaid-eligible individuals who are incarcerated, up to 30 days before their release from jail or prison. Passage of these critical pieces of legislation would be an important step towards reducing SUD-related mortality.

Conclusion

Effecting systemic change to improve SUD Care in federal health programs presents formidable challenges due to stigma and entrenched ways. Nevertheless, bold action is required of the Subcommittee as lives are at stake. Thank you for your leadership. If you have any questions or need further clarification, please do not hesitate to contact Kelly Corredor, ASAM's Chief Advocacy Officer, at kcorredor@asam.org.

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