July 6, 2021

Regina M. LaBelle
Deputy Director and Acting Director
Office of National Drug Control Policy (ONDCP)
1600 Pennsylvania Ave., NW
Washington, DC 20500

RE: 2022 National Drug Control Strategy

Dear Ms. LaBelle:

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 6,600 physicians and associated health professionals who specialize in the prevention and treatment of addiction, thank you for the opportunity to provide input on the Biden-Harris Administration's 2022 National Drug Control Strategy (Strategy). ASAM commends the Administration's commitment to addressing the addiction and overdose crisis, especially as the COVID-19 pandemic has only exacerbated pervasive health and social inequities.

As you know, drug overdose death rates have recently reached historic highs. Estimates of drug overdose deaths exceed 92,000 for the 12-month period to October 2020,[1] with overdose death rates surging among Black and Hispanic Americans.[2] Alcohol consumption also increased 17 percent between 2019 and 2020.[3]

These spikes in substance use and overdose deaths certainly reflect a combination of increasingly deadly illicit drug supplies, treatment disruptions, social isolation, and other hardships imposed by the COVID-19 pandemic, but they also reflect the longstanding inadequacy of our medical infrastructure when it comes to preventing and treating addiction. Even before the COVID-19 pandemic began, more than 21 million Americans aged 12 or over in 2019 needed treatment for a substance use disorder (SUD) in the past year, but only about 4.2 million of them received any treatment or ancillary services for it.[4]

Given these daunting statistics, ASAM appreciates the opportunity to detail recommendations that are crucial to addressing this

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crisis. Namely, ASAM encourages the Administration to include support for the following in the Strategy:

- actions to strengthen the addiction medicine workforce;
- efforts to standardize the delivery of individualized addiction care;
- measures to ensure equitable access and coverage for comprehensive, high-quality addiction care, in ways that reduce racial, ethnic, and economic disparities; and
- regulatory and administrative efforts to reduce barriers to accessing evidence-based addiction treatment.

Strengthen the Addiction Medicine Workforce

Addiction is a treatable, chronic medical disease, but there are not enough physicians and other clinicians who are educated and trained to specialize in the prevention and treatment of addiction. In fact, only 1 in 4 health care professionals recently surveyed in Massachusetts[5] received training about addiction during their medical education; this survey also shows that a shocking number of those surveyed believe — incorrectly — that opioid use disorder (OUD) cannot be treated at all. Additionally, according to a 2020 report released by the Substance Abuse and Mental Health Services Administration (SAMHSA), the United States needs more than 40,000 additional addiction medicine specialist physicians and more than 40,000 additional addiction psychiatrists to meet our nation's SUD workforce demands.[6] Further, by 2025, it is estimated that there will be a workforce shortage of up to 250,000 selected behavioral health practitioners in the addiction/mental health field.[7] These statistics and other workforce shortage estimates[8] reinforce the urgent need to ensure our health care workforce has an adequate supply of medical professionals who can meet the needs of the more than 20 million Americans, including adolescents, who require addiction treatment. Therefore, ASAM recommends that policies reflected by the following Congressional efforts be included in the Strategy:

- *S 1438/HR3441 – Substance Use Disorder/Opioid Workforce Act*: This legislation would provide an additional 1,000 Medicare graduate medical education (GME) slots to qualifying hospitals that have established, or will establish, approved residency programs in addiction medicine, addiction psychiatry, pain medicine, and corresponding prerequisite programs;
- Increased appropriations for the Health Resources and Services Administration (HRSA)'s Substance Use Disorder Treatment and Recovery Loan Repayment Program. This program, authorized in the SUPPORT for Patients and Communities Act, will provide flexible and substantial student loan repayment for addiction treatment professionals who commit to working in underserved or high-risk communities. Eligibility for this particular loan repayment program is expansive in terms of eligible disciplines, including addiction counselors, behavioral health paraprofessionals, and clinical support staff, as well as the inclusion of a variety of addiction facility types. In addition, applicants do not need to be recent graduates;
- Increased appropriations for HRSA's Addiction Medicine Fellowship Program. This program, authorized in the 21st Century Cures Act, provides grants to institutions with

training opportunities for fellows in addiction medicine and addiction psychiatry who have demonstrated interest in providing addiction treatment in underserved communities;

- Increased appropriations for HRSA's Integrated Substance Use Disorder Training Program. This program, also authorized in the 21st Century Cures Act, provides grants to expand the number of nurse practitioners, physician assistants, psychologists, and social workers trained to provide addiction and mental health services in underserved community-based settings that integrate primary care, mental health, and addiction services. Addiction treatment in the U.S. is often delivered to patients using multidisciplinary care models of health care professionals who work together to address patients' biopsychosocial needs; and
- Increased appropriations for federal initiatives that lead to a more diverse addiction treatment workforce, such as scholarships and loan repayment targeting underrepresented minority addiction medicine professionals. For example, SAMHSA's Minority Fellowship Program should be expanded to include an eighth medical society representing addiction medicine specialist physicians.

Standardize the Delivery of Individualized Addiction Care

Efforts to strengthen the addiction medicine workforce should be coupled with investments aimed at standardizing the delivery of individualized addiction care and mainstreaming it throughout health care systems, including federal health services provided by the Indian Health Service. Wide variability in addiction medicine training and treatment have prevented far too many Americans from accessing evidence-based care for this chronic, treatable disease. Accordingly, ASAM recommends that the Administration include support for the following policies in the Strategy:

- Alignment of coverage and payment policies in Medicare[9] and Medicaid with evidence-based and nationally recognized addiction treatment and placement criteria and standards (e.g., *The ASAM Criteria*). For example, this should include permanent modification to the Institutions for Mental Diseases (IMD) exclusion to allow federal Medicaid funds to serve individuals with SUDs in those residential and inpatient settings that are able to demonstrate that patient assessments, clinical services, level-of-care and length-of-stay recommendations are consistent with *The ASAM Criteria* and that evidence based medication management using Food and Drug Administration (FDA)-approved medications are available to patients in such settings;
- Regulatory/sub-regulatory/application guidance that would require the use of evidence-based practices in the Substance Abuse Prevention and Treatment (SAPT) Block Grant, including requiring each grantee delivering SUD treatment services to provide access to all FDA-approved medications for SUDs treated by that grantee. In addition, SAPT, State Opioid Response Grant (SOR), and Rural Communities Opioid Response Program grantees that receive grant funds for the delivery of addiction treatment services should be limited to Medicaid providers in order to better integrate federal grant dollars and Medicaid funds and increase oversight.[10] While grant funding through the annual appropriations process is not unwelcome, the Administration should encourage improved mechanisms for ensuring that such funding does not supplant the consistent and scalable funding that Medicaid (or Medicare) provides; and

- *S 2235/HR 2067 – Medication Access and Training Expansion (MATE) Act of 2021*: This legislation would ensure most Drug Enforcement Agency (DEA) controlled medication prescribers have a baseline knowledge of how to identify, treat, and manage patients with SUD and would allow accredited health professional schools and residency programs to fulfill the training requirement through their own curricula, as well as provide them with resources to do so. We would also encourage the Strategy to include support for simultaneous passage of S 445/HR 1384 - *Mainstreaming Addiction Treatment (MAT) Act,* which would eliminate the requirement that practitioners apply for a separate waiver through the DEA to prescribe buprenorphine for addiction and eliminate the patient limits on buprenorphine prescribers.

Cover and Appropriately Reimburse for Addiction Medicine

In addition to efforts to expand the addiction medicine workforce and use policy levers to standardize the delivery of individualized addiction care, ASAM encourages the Strategy to include support for other regulatory and administration efforts that would increase equitable access to, and coverage for, comprehensive, high-quality addiction care for all. Accordingly, ASAM recommends that policies reflected by the following Congressional efforts be included in the Strategy:

- *S 285/HR 955 – the Medicaid Reentry Act*: This legislation would allow for re-establishment of health insurance coverage under Medicaid for eligible individuals who are incarcerated, during the 30-day period preceding their release from jail or prison. In addition, support S 1821/HR 3514 - the Humane Correctional Health Care Act, which would repeal the "inmate exclusion" that bars the use of federal Medicaid matching funds from covering health care services in jails and prisons; in June 2021, the American Medical Association's House of Delegates adopted new policy calling for that repeal;[11]
- *S1727/HR 3450 - The Medicaid Bump Act of 2021*: This legislation would provide an enhanced Medicaid Federal Medical Assistance Percentage rate of 90 percent for State Medicaid spending on mental health and substance use disorder services in excess of 2019 levels. It would also require states to use the additional federal funds as a supplement to rather than a replacement for state funding levels, and to use the funds to increase the capacity, efficiency, and quality of behavioral health services, including through increasing provider reimbursement rates;
- *Section 9 of S. 1010 – the Turn the Tide Act* – These provisions would increase Medicaid fees for addiction treatment services to at least Medicare levels;
- *HR 1364 - the Parity Enforcement Act*: This legislation would expand the U.S. Department of Labor's authority to hold health insurers and plan sponsors accountable for offering health plans that violate the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 or for employing utilization review processes that prove more restrictive for mental health and addiction care than for other medical care in violation of the MHPAEA;
- *S 340/HR 1674 - TREATS Act*: This legislation would make permanent a new, audio-video, telehealth evaluation exception to the Ryan Haight Act's in-person exam requirement, which would allow clinicians to prescribe certain addiction treatment medications, like buprenorphine, to new patients through telehealth. It would also clarify Medicare's continued ability, beyond the COVID-19 public health emergency, to reimburse for

audio-only, SUD and mental health telehealth services after an in-person or telehealth evaluation; and
- *HR 3925 Reducing Barriers to Substance Use Treatment Act*: This legislation would prohibit states receiving Federal funding for "medication-assisted treatment" under Medicaid from imposing utilization control policies or procedures (as defined by the Secretary of the Department of Health and Human Services), including prior authorization requirements, with respect to such treatment.

Additionally, ASAM encourages the Administration to commit to the following initiatives in the Strategy:

- Continuous collaboration and sharing of information between the Centers for Medicare & Medicaid Services (CMS) and SAMHSA, which should include new, strategic efforts to provide technical assistance funds to states to support their operation of CMS-approved Section 1115 SUD waivers related to the IMD exclusion and to enhance their care delivery systems for patients. HHS could use the new Behavioral Health Coordinating Council as the vehicle for this collaboration; and
- Increased promotion to State Medicaid programs of adoption of two, new sets of bundled G codes to increase or establish payment for outpatient opioid use disorder (OUD) treatment and treatment services provided by opioid treatment programs (OTPs) at Medicare payment rates or higher. In 2021, the outpatient OUD codes were expanded to provide payment for the treatment of any SUD. The outpatient codes provide higher payment for the initial month of treatment to cover intake activities and the development of a treatment plan. The OTP code set includes an add-on code to describe intake activities including the initial medical examination and assessment.

Reduce Other Barriers to Addiction Treatment

Finally, ASAM recommends that the Administration include support for the following regulatory and administrative efforts that would reduce barriers to accessing addiction treatment:

- Creation of safe-harbor provisions to the Anti-Kickback Statute and Eliminating Kickbacks in Recovery Act Civil, as they may be applied to the implementation of contingency management (CM) for the treatment of addiction. ASAM has detailed the evidence behind CM and the case for creating safe-harbors here;[12]
- Approval of a prescription to over the counter (OTC) switch for at least one naloxone product. This change would save lives and reduce existing barriers that prevent access to this critical medication;
- Regulatory changes that would allow Medicaid reimbursement for the room and board portion of SUD residential levels of care that meet level of care standards set forth in *The ASAM Criteria*;[13]
- Regulatory (or legislative) changes that would create a special registration exemption for jails, prisons, and their authorized personnel to prescribe and otherwise dispense controlled medications for initiation, maintenance or withdrawal management of OUD that is significantly less burdensome than currently applicable registration requirements in the Controlled Substances Act and related regulations. Such special registration should

not limit the number of persons who are detained or incarcerated who can be treated with such medications by a qualified practitioner;

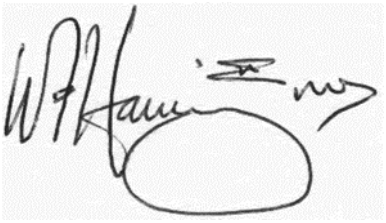
- Regulatory (or legislative) changes that would allow pharmacy dispensing and/or administration of methadone that has been prescribed by a legally authorized prescriber of controlled medications who is affiliated with an OTP or a board-certified addiction specialist physician for patients who meet certain criteria. Pharmacist dispensing of methadone ordered by a physician or other authorized prescriber has been a model used outside of the United States;
- Regulatory (or legislative) changes that would make permanent the opioid treatment program (OTP) flexibilities, including the methadone unsupervised dosing flexibilities, implemented during the COVID-19 Public Health Emergency while continuing study of the impact of these flexibilities;
- Assessment of current opioid order systems and monitoring programs to more fully understand the potential negative implications for patient access to buprenorphine at pharmacies and other controlled substance medications used to treat OUD. At a minimum, this assessment should determine the frequency with which a pharmacy places an order for buprenorphine that is either not fulfilled by the distributor or is reported by the distributor as suspicious. This assessment should also use available data to analyze whether pharmacy orders for buprenorphine and subsequent patient access is being unnecessarily stifled and consider solutions. ASAM remains deeply concerned that current policies prioritize efforts to reduce diversion of buprenorphine and disregards patients' access to needed OUD treatment. Click here for additional background and related advocacy from ASAM;
- In the absence of Congressional action to eliminate the x-waiver, efforts to increase the DATA 2000 waiver patient limit -- aka, the "applicable number." Click here[14] for an April 2020 letter from U.S. Senators regarding a related proposal. In addition, pursuant to 21 USC 823(g)(2)(B)(iii)(IV), this effort should include exclusion from the "applicable number" patients whose controlled medications are directly administered by a qualified practitioner in an office setting; and
- Issuance of regulations relating to a special registration for telemedicine, as was directed in Section 3232 of the SUPPORT Act of 2018. The treatment field needs these regulations (as authorized by law) to be implemented. The criteria for such special registration should align with the bipartisan, bicameral TREATS Act of 2021 (described above).

The list of actions described above would have a tremendously positive impact on addiction care throughout this nation. Now, more than ever, we must ensure that our overall national investment in prevention and treatment services for addiction isn't disproportionately outsized by our spending on the treatment of medical, surgical, obstetrical, or psychiatric complications of substance use.

ASAM is encouraged by the Administration's release of its Statement of Drug Policy Priorities for Year One. We look forward to continuing to work with your Office and with others in the Administration to strengthen the addiction medicine workforce, standardize the delivery of individualized addiction care, and expand addiction medicine coverage, payment, and access.

Thank you for the opportunity to share ASAM's input on the Administration's 2022 National Drug Control Strategy. If you have any questions or concerns, please contact Kelly Corredor, ASAM's Chief Advocacy Officer, at kcorredor@asam.org.

Sincerely,



William F. Haning, III, MD, DLFAPA, DFASAM
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