August 14, 2017

The Honorable Chris Christie
Chair, President's Commission on Combating Drug Addiction and the Opioid Crisis
Eisenhower Executive Office Building
1650 Pennsylvania Ave NW
Washington, DC 20502

Dear Governor Christie,

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 4,500 physicians and allied health professionals who specialize in the prevention and treatment of addiction, thank you for the opportunity to provide comments on the interim report of the Commission on Combating Drug Addiction and the Opioid Crisis and offer suggestions for additional recommendations that should be included in the final report to the President.

ASAM agrees that our nation is in a crisis. Opioid overdoses and deaths continue to devastate families and communities across the country, and it is imperative that the Administration take immediate action to increase access to evidence-based addiction treatment and recovery support services, as well as take steps to enhance prevention and early intervention efforts. Steps can and should be taken by the Administration in 2017 to prevent deaths and engage people in treatment, while laying the groundwork for more robust addiction treatment systems and workforce in the near future.

ASAM appreciates the thoughtful work the Commission has put into its interim report, and respectfully offers the comments below for the Commission's consideration as it crafts its final report to the President. ASAM's comments on the content of the interim report are followed by additional strategies to combat the opioid epidemic that ASAM believes should be included in the Commission's final recommendations.

**Declaration of National Emergency**

ASAM greatly appreciates the urgency of the Commission's recommendation for the President to declare a national emergency under either the Public Health Service Act or the Stafford Act. The opioid overdose epidemic should raise the same level of alarm as other national emergencies, such as a pandemic influenza or a natural disaster. However, unlike infectious diseases, opioid addiction is a chronic disease requiring long-term, and often life-long,

treatment. And unlike a natural disaster, the devastating effects of this epidemic cannot simply be cleaned up and repaired with a short-term infusion of money and manpower.

Combatting this chronic-disease epidemic will require systemic and sustainable changes to our addiction treatment financing structures, addiction treatment workforce, clinical training programs, and public understanding of the disease and evidence-based approaches to treatment. Time-limited policy changes and short-term investments that can be made pursuant to a declaration of national emergency can set the stage for these broader and permanent changes, but in and of themselves will not suffice to reverse the course of this epidemic.

ASAM urges the Commission recommend specific action items for the President and Secretary of Health and Human Services (HHS) to act upon pursuant to a declaration of national emergency, should it be declared, including:

- Emergency funding to train healthcare providers in evidence-based opioid addiction treatment practices. Such training can bolster the existing workforce and increase the provision of treatment services that have been demonstrated to lead to positive and lasting outcomes.
    - This training should be provided to primary care practitioners, addiction treatment counselors, social workers, pharmacists, correctional health professionals, drug court professionals, and other professionals who provide healthcare and social services to patients with addiction.
    - Such training should cover the latest science on the disease of addiction and the evidence-based treatment approaches available.
    - Funding should be provided both to cover the costs of training as well as to incentivize providers to take it.
    - Training should cover the same topics and competencies that are outlined in the Section 303 of the Comprehensive Addiction and Recovery Act (CARA).
    - Training should be approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) or be delivered by a SAMHSA-approved educational provider.
    - Funding should also be made available to train those desiring to become expert clinical practitioners and clinical educators: addiction specialist physicians. Such specialists will be in position to lead multidisciplinary clinical teams and train other physicians, primary care practitioners, and other professionals to provide the highest quality and evidence-based treatments to those in need.
- Funding to replicate or scale promising practices to connect patients who have experienced an overdose to treatment. Too often, patients who have experienced an overdose are discharged from an emergency department with little more than a phone number to call for ongoing treatment. With appropriate design of services and training of staff, direct services to address addiction can be offered in the emergency department itself to the person who has been revived from an overdose. Then, handoffs from emergency departments to evidence-based treatment services should be seamless and coordinated so that patients are engaged in treatment quickly. Funding should also prepare primary care clinics as well as addiction

specialty clinics to receive referrals from hospitals and offer evidence-based interventions to begin the process of chronic disease management for the addiction that led to the overdose.

**IMD Exclusion Waivers**

ASAM supports the elimination of the IMD exclusion **for those residential treatment providers that are able to deliver services consistent with the ASAM Criteria and provide evidence-based substance use disorder treatment, including FDA-approved agonist and antagonist medications for opioid use disorder treatment**. As the current Medicaid 1115 waiver opportunity requires, prior to participating in the Medicaid program and rendering services to beneficiaries, treatment centers should demonstrate that they are appropriately staffed and provide treatment services based on a comprehensive patient assessment and individualized treatment plans. It is imperative that HHS target these waivers to facilities that demonstrate alignment with industry standards and evidence-based practices to prevent wasteful federal spending on treatment programs that do not have the capacity to offer the range of services proven to produce positive outcomes. This will require the programs to demonstrate that their patients with opioid addiction, upon discharge, have been referred to continue treatment in their communities

**Prescriber Education Initiatives**

ASAM strongly supports the Commission's recommendation that the President instruct the Department of Justice (DOJ) and the Drug Enforcement Agency (DEA) to require continuing medical education for every clinician requesting an initial DEA license or the renewal of such a license in order to be allowed to prescribe controlled substances. Such education should cover safe controlled substances prescribing practices, pain management, and substance use disorder identification and treatment.

The Commission should broaden its recommendations related to prescriber education to include clinical school curricula and residency programs. Health care professionals-in-training currently receive very little formal instruction on these topics and feel unprepared to manage pain or identify and treat patients with addiction upon completion of their training. Our nation's health professions schools should be obligated to equip the next generation of health care professionals with the knowledge and skills needed to address the opioid epidemic. HHS should work with the American Association of Medical Colleges (AAMC), the American Association of Colleges of Nursing (AANC), and other relevant clinical school associations to improve their course offerings and the competencies of their graduates in pain management and addiction treatment.

**Access to Pharmacotherapy for Opioid Use Disorder**

ASAM agrees, as the interim report notes, that medications for the treatment of addiction involving opioid use are "proven to reduce overdose deaths, retain persons in treatment, decrease use of heroin, reduce relapse, and prevent spread of infectious disease" and that expanded access to medications must be a part of the federal response to the opioid epidemic.

**However, the interim report suggests that the President "require…all modes of MAT [be] offered at every licensed MAT facility." ASAM strongly urges the Commission to clarify this recommendation in its final report, so that it is not taken to mean that pharmacological therapies for addiction may only**

**be offered through federally-certified opioid treatment programs (OTPs), which are the only facilities where methadone can be offered for addiction treatment.** Such a requirement would eliminate access to office-based treatment with buprenorphine and naltrexone, as office-based clinicians are not licensed to dispense methadone and could not comply with the requirement to offer all modes of MAT. Simply put, unless reworded, this requirement would devastate access to evidence-based treatment and leave thousands of patients without access to care, the exact opposite of the Commission's stated goal of increasing access to MAT.

Instead, ASAM urges the Commission to make recommendations to improve the frequency with which conventional drug treatment facilities provide medications for opioid use disorder. The interim report notes that "approximately 10 percent of conventional drug treatment facilities in the United States provide MAT for opioid use disorder," but does not recommend how change that. ASAM suggests that the Commission recommend federal financial participation for Medicaid expenditures to an IMD under a waiver of the IMD Exclusion be limited to those inpatient facilities that have demonstrated their ability and willingness to adopt and offer medication management, as indicated, for patients in those facilities.

Finally, ASAM supports the interim recommendations that:

- The DOJ, in consultation with HHS and ONDCP, should be directed to increase the use of all three types of pharmacotherapy for opioid use disorder in federal correctional settings. This effort should include the entire continuum of the criminal justice system, from pre-trial custody settings, to prisons and jails, to community corrections (probation and parole) programs, and to drug courts. Additionally, we recommend that ONDCP should make every effort to encourage state and local correction facilities, drug courts, probation and parole and reentry programs to adopt best practices in the treatment of opioid use disorder, including the of **all** FDA-approved medications for opioid addiction treatment. Individuals released from correctional facilities back into the community who have addiction involving opioids as one of their health conditions should be able to be treated with addiction pharmacotherapies, as indicated, prior to and through their date of release so that there are no gaps between a stay in a prison or jail and admission to a community-based clinic where medications can be offered and managed.
- The Health Resources and Service Administration (HRSA) should require all federally-qualified health centers (FQHCs) to mandate that their staff physicians, physician assistants, and nurse practitioners possess waivers to prescribe buprenorphine. Funding should be increased to FQHCs that offer office-based addiction treatment services with buprenorphine and naltrexone.
- CMS should send a letter to state health officials requesting that state Medicaid programs cover all FDA-approved MAT drugs for opioid use disorder.
- CMS should revise Medicare policies to cover methadone treatment at opioid treatment programs.

**Naloxone Access**

ASAM supports the interim report's recommendations related to improved access to naloxone, including support for standing orders, law enforcement use, and Good Samaritan laws. As stated above, we urge the Commission to include an additional recommendation for federal funding to replicate or

scale promising practices to connect patients who have experienced an overdose to addiction treatment services.

Finally, there has been some debate about the value of making naloxone an over-the-counter medication. The federal government should commission a study into the possible benefits and drawbacks of this approach, and work with manufacturers to change naloxone's prescription status if the identified benefits prove to exceed the harms.

**Prescription Drug Monitoring Programs (PDMPs)**

ASAM supports the interim report's recommendations to provide federal funding and technical support to states to enhance interstate data sharing among state-based prescription drug monitoring programs (PDMPs). This funding should also be made available to integrate PDMP data into electronic medical records and clinicians' normal workflow.

In addition to improving and integrating these programs, ASAM recommends HHS support the development of training for primary care providers to know how to engage a patient whose PDMP report indicates he or she may be inappropriately accessing controlled substances. Without such training, many clinicians might simply dismiss patients from their practice without an assessment for substance use disorder or referral to treatment, if indicated. These clinicians are missing an important opportunity to engage patients in treatment, and should be equipped to use the PDMP report as a conversation-starter with patients at risk of addiction or overdose death.

**Patient Privacy Laws**

ASAM supports the interim report's recommendation to align, through regulation, patient privacy laws specific to addiction with the Health Insurance Portability and Accountability Act (HIPAA) to ensure that information about SUDs be made available to medical professionals treating and prescribing medication to a patient. However, this alignment should only cover disclosures of healthcare information for treatment, payment, and healthcare operations. All other disclosures – for example, to law enforcement officials, employers, landlords, child welfare agencies, and disability and life insurance agents – should remain covered by 42 CFR Part 2.

**Mental Health Parity and Addiction Equity Act (MHPAEA) Enforcement**

ASAM agrees that we need more robust enforcement of the federal parity law by the state and federal agencies. A standardized parity compliance tool would be a valuable enforcement mechanism, and should be developed expeditiously.

**Other Issues and Recommendations**

*National Prevention Strategy*

ASAM agrees that a sophisticated and robust national prevention strategy in direly needed. We recommend that **the Centers for Disease Control and Prevention (CDC) launch a public awareness campaign to educate the public and health care providers about addiction as a chronic brain disease**

**that can be effectively treated with evidence-based interventions.** Public education should include information about the types of treatment options that have been shown to be effective, such as medications for opioid addiction, so that patients and families know how to identify quality treatment services. Only the federal government has the capacity and reach to raise public awareness effectively. We saw this in the 1980's with the CDC's America Responds to AIDS public information campaign (1987), and the distribution of Understanding AIDS (1988), a brochure that was delivered to every residential mailing address in the United States. Opioid overdose deaths have surpassed deaths at the height of the AIDS crisis, yet we have not seen similar efforts to educate the public about the disease of addiction or the treatment they should seek.

*Workforce Needs*

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 training to meet the treatment needs of the estimated 19.4 million Americans suffering from untreated substance use disorders. To make a meaningful and sustainable impact on the current opioid overdose epidemic, and to stave off future epidemics related to other addictive substances such as cocaine, benzodiazepines or methamphetamine, it is imperative that our nation invest in training opportunities for clinicians seeking to specialize in addiction treatment.

- The Commission should include in its report a recommendation that the federal government fund ACGME-accredited addiction medicine and addiction psychiatry fellowship positions and create a loan repayment program for physicians who complete these fellowships and enter into the practice of addiction medicine or addiction psychiatry. There are two concrete steps that can be taken to accomplish this goal: Congress should **(1) fully appropriate $10 million in funding for Section 9022 of the 21st Century Cures Act**, which authorizes the Secretary to establish a training demonstration program within the Health Resources and Services Administration (HRSA) to award grants for medical residents and fellows to practice psychiatry and addiction medicine in underserved, community-based settings, and **(2) revise the Public Health Service (PHS) Act to include addiction medicine specialists in the definition of "behavioral and mental health professionals" within the National Health Service Corps**. Beyond these steps, we strongly urge the Administration to identify robust and ongoing funding opportunities **that can be used to support addiction specialist training programs,** to build an adequate workforce to have a substantial and sustained impact on this epidemic**.**
- The Commission should recommend that HHS and ONDCP should coordinate efforts among federal agencies to **raise awareness among qualified physicians of the opportunity to sit for the addiction medicine subspecialty board exam**. In 2016, addiction medicine was recognized as an American Board of Medical Specialties (ABMS) subspecialty under the American Board of Preventive Medicine (ABPM). The first ABMS addiction medicine board exam will be offered in October 2017. While the board exam will be open to any American physician with a primary ABMS board certification until 2022, after that time period, physicians will need to complete a year-long fellowship program to be qualified to sit for the exam. In five short years, the number of accredited and funded addiction medicine fellowship programs and slots will be the limiting factor in determining how many addiction medicine specialists can receive board certification. It is critical that all stakeholders work to maximize funded addiction medicine fellowship opportunities before their number begins to limit qualified examinees. Additionally, in the years leading up to 2022, ASAM urges that the report

recommend that HHS and ONDCP should coordinate efforts among federal agencies to raise awareness among qualified physicians of the opportunity to take the board exam without completing a fellowship program.

*Quality of Care*

The Commission's final report should include action items related to quality of care. ASAM is committed to promoting evidence-based addiction treatment, and has heard often from policymakers and payers about the challenges they face in identifying and rewarding high-quality care. 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 in terms of clinical guideline development and quality measurement. ASAM recommends HHS and ONDCP expand efforts to promote quality of care to include:

- Support for the development and dissemination of clinical practice guidelines for addiction treatment, such as the ASAM *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*,
- Support for the development and validation of quality measures for addiction treatment, and
- Support for treatment center and/or clinician certification programs that could provide patients, families, and payers with a reliable indicator that providers are delivering a certain quality or level of care.

Efforts such as these 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.

Thank you for the opportunity to comment as the Commission develops its report. We stand ready to serve as a resource to you.

Sincerely,

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

CC: The Honorable Charlie Baker
The Honorable Roy Cooper
The Honorable Patrick Kennedy
Bertha Madras, PhD