



ASAM American Society of
Addiction Medicine

American Society of Addiction Medicine (ASAM) Testimony, US House Committee on Energy and Commerce, Health Subcommittee, “Combatting an Epidemic: Legislation to Help Patients with Substance Use Disorders”

Shawn Ryan, MD, MBA, FASAM
Chair, ASAM Legislative Advocacy Committee
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Introduction

Chairwoman Eshoo, Ranking Member Burgess, and esteemed Members of this Subcommittee, thank you for inviting me to participate in this important hearing. My name is Dr. Shawn Ryan. I am a board-certified addiction specialist and a board-certified emergency physician, and I care for patients with addiction in Cincinnati, Ohio. I am also the Chair of the Legislative Advocacy Committee of the American Society of Addiction Medicine, known as ASAM, a national medical society representing over 6,000 physicians and other clinicians who specialize in the prevention and treatment of addiction.

I’d like to begin by recognizing the diligent and dedicated work Congress has done over the past five years to advance crucial pieces of legislation to address America’s addiction and overdose crisis. The Comprehensive Addiction and Recovery Act, the 21st Century Cures Act, and the SUPPORT for Patients and Communities Act, along with the additional funding made available through the State Targeted Response (STR) and State Opioid Response (SOR) Grants, have made a life-or-death difference for many patients, families, and communities. Thank you.

Still, we continue to see the ravages of addiction across the country. Even while we celebrate the first [decline](#) in national drug overdose deaths in nearly 30 years, we are concerned by rising death rates from synthetic opioids like fentanyl and psychostimulants like methamphetamine – and many communities are still seeing increases in opioid overdose deaths.

Much more work needs to be done to create a sustainable and robust addiction prevention and treatment infrastructure – one that addresses addiction as the *treatable, chronic medical disease* that it is.

To realize this vision, Congress must focus on three, big things:

1. Increasing the number of qualified, well-trained addiction treatment professionals and ensuring all healthcare professionals receive basic training in addiction prevention, diagnosis, and treatment. We must adequately teach addiction medicine to those who are, and will be, on the frontlines of this crisis;
2. Standardizing the delivery of individualized addiction care to ensure our nation's addiction prevention and treatment infrastructure can meet the needs of those with substance use disorder (SUD) and is aligned with the science. This will involve rethinking how we target our grant programs and holding grantees accountable for the funds they receive; and
3. Reforming payment policies and strongly enforcing mental health and addiction parity so that people suffering from substance use and mental health disorders are adequately covered for high-quality, comprehensive care.

Teach Addiction Medicine

Focusing first on our workforce needs, I'm sure you know that there are far too few physicians and other clinicians with the requisite knowledge and training to assess and treat addiction. There are roughly 3,000 board-certified addiction specialist physicians in this country, according to a 2018-2019 [report](#) by the American Board of Medical Specialties, and according to a recent [survey](#), only one in four Massachusetts healthcare providers report receiving training on addiction during their medical education. For a country that prides itself on the medical care available to its citizens, this is simply unacceptable, especially in the face of an epidemic that has been raging for years.

We must increase our healthcare workforce's knowledge base about addiction and comfort level treating patients who suffer from it, and we must invest in training specialists to lead care teams and treat the most complex cases.

That is why ASAM strongly supports passage of the **Opioid Workforce Act**, legislation that would provide an additional 1,000 Graduate Medical Education (GME) slots to qualifying hospitals with approved programs in addiction medicine, addiction psychiatry, pain medicine, and corresponding prerequisite programs. By passing the Opioid Workforce Act, we can improve training for addiction treatment professionals and bolster the workforce.

In addition, to ensure more healthcare providers receive basic training in addiction prevention, diagnosis, and treatment, we urge Congress to pass the **Medication Access and Training Expansion (MATE) Act**. This legislation would require all DEA controlled medication prescribers to have a baseline knowledge of how to prevent, identify, treat, and manage patients with SUD and would allow accredited medical schools and residency programs and schools training future physician assistants and advanced practice registered nurses to fulfill the training requirement through comprehensive curriculum.

Dr. James Baker, whose presence we are privileged to have today, is sitting behind me. He has been a determined champion of the MATE Act. I am awed by his courageous advocacy in honor of his son Max, whose promising young life was cut short by an opioid overdose, in part because the medical community Max encountered had yet to reckon fully with the disease of addiction.

Passage of the MATE Act would help normalize addiction medicine education across professional schools and phase out the need for these future practitioners to take a separate, federally mandated addiction training course. Accordingly, ASAM also supports the passage of the **Mainstreaming Addiction Treatment Act**, after or concurrent with, passage of the MATE Act to eliminate what would then be a clearly redundant requirement that practitioners apply for a separate DEA waiver to prescribe buprenorphine for addiction treatment, along with the waiver's patient limits and extra regulatory burdens on buprenorphine, a life-saving medication to help treat opioid use disorder (OUD).

Standardize Addiction Care

Our workforce shortage is exacerbated by a long history of treating addiction in siloed settings separate from medicine, where available treatment is largely determined by local culture rather than nationally recognized standards of care. While treatment should be individualized to a patient's disease severity and preferences, there are generally accepted standards of care for addiction treatment that should be practiced in every treatment setting. Unfortunately, this is not the case. We know too few treatment programs offer the standard of care for OUD: evidence-based behavioral therapies and medication treatment. SAMHSA [estimates](#) that less than four in ten patients with OUD receive treatment with medications. In other studies, the rates of appropriate medication usage are worse. We would not accept this in any other part of American medicine such as for heart disease or diabetes.

Standardizing treatment so that patients are matched to the best level of care and receive the standard of care no matter where they seek treatment will require a significant investment of resources to educate, equip, and certify addiction treatment programs as well as sufficient political will to make difficult choices about what kinds of treatment we will continue to subsidize.

ASAM urges Congress to further strengthen its grant-based response to this addiction and overdose crisis in a way that targets resources to those clinicians and programs that (1) offer patient-centered, evidence-based care and (2) aim to connect with mainstream medical care systems and financing. Doing so will ensure that, when these time-limited investments run out, states will be left with sustainable and effective treatment systems.

To that end, ASAM would support, as a foundational, multi-year response to this crisis, H.R. 2466, the **State Opioid Response Grant Authorization Act** with amendments to (1) align its authorized funding with the FY20 enacted amount of \$1.5 billion; (2) authorize the use of funds to allow for treatment of stimulant use disorder, and (3) strengthen the program by applying a

long-standing, bipartisan provision from the Ryan White CARE Act, which is also included in the late Rep. Elijah Cummings' CARE Act of 2019, that would require certain grantees to enroll as Medicaid providers, beginning in FY21. This last amendment would ensure those grantees can meet minimum national standards for healthcare providers and would better assure Congress that funds are used as they were intended – to pay for crucial wraparound and support services that facilitate recovery but cannot be billed to Medicaid.

Now, we recognize other grant responses are being considered, such as H.R.2922, the **Respond to the Needs in the Opioid War Act**, H.R. 4793, the **Budgeting for Opioid Addiction Treatment Act** – both subject of this hearing – and H.R. 2569, the **CARE Act**, which would authorize \$100 billion over 10 years, a funding amount that is more aligned with the magnitude of this crisis.

However, as the CARE Act also acknowledges, we need to ensure that any significant future increases in investments in addiction prevention and treatment are efficient and effective. Continued funding must drive systemic change by integrating federal grant funding with the way we normally pay for medical care in this country. Doing so will help establish a sustainable treatment infrastructure that is subject to the same quality oversight as other fields of medicine and move us closer to achieving the vision set by the Mental Health Parity and Addiction Equity Act more than a decade ago.

For example, Congress could establish a treatment infrastructure grant program to supplement the SOR program for all SUD with conditions that require states and localities to adopt additional strategic policy changes modeled on ideas in the CARE Act. To qualify for this supplemental funding, states could be required to adopt standards for the regulation of SUD treatment programs based on nationally recognized treatment levels of care, such as *The ASAM Criteria*. Such a requirement would help standardize the current patchwork of state treatment program licensure regulations, making oversight and payment more efficient and setting baseline expectations for patients seeking care. States could also be required to adopt policies that would require health plans in their state to use medical necessity criteria that follow generally accepted standards of care for addiction, as defined by national medical specialty society guidelines. By aligning addiction treatment program levels of care with insurer medical necessity criteria, our nation could take a giant leap closer to achieving the promise of parity. Finally, grantees of these new treatment infrastructure grants could be required to offer, either directly or through affiliation agreements, all FDA-approved medications for the treatment of SUD. Over time, our hope would be that the largest federal grant programs targeting addiction treatment could then be combined with a common set of modernized requirements that fully welcome the treatment of addiction into modern-day health care.

But let's be clear, Congress and the American taxpayer are having to issue these kinds of grants because, despite 10 years since federal parity law passed, parity is not a reality. Recent [lawsuits](#) have found payers continue to make discriminatory coverage decisions, and [reports](#) have documented the wide disparity in network use and provider payment rates between mental health/addiction treatment and general medical care.

Without standardizing the delivery of addiction treatment, aligning federal funding with established payment structures, and proactively enforcing the parity law, we are facilitating a “really bad deal” for the federal government and the American people, who are financing billions of dollars in grants to treat a chronic medical disease when it should be fairly and comprehensively covered by health plans in this country.

Cover Addiction Care

This now brings us to the bills being considered in this hearing that seek to improve insurance coverage of addiction treatment – bills that target the most vulnerable in our society—persons who are incarcerated: H.R. 1329, the **Medicaid Reentry Act** and H.R. 4141, the **Humane Correctional Health Care Act**.

[Studies](#) have found that nearly two-thirds of prison inmates have a history of SUD, and an additional 20 percent didn’t meet criteria for SUD at the time of their crime but did have substance involvement or were arrested for a drug-related offense. Specifically, detainment in correctional settings can pose treatment challenges for individuals with OUD: those who are in treatment prior to incarceration may be forced to discontinue treatment, and those with untreated OUD are often not offered evidence-based and life-saving treatment upon entering [jail](#) or [prison](#).

Furthermore, upon release, individuals whose OUD treatment has been discontinued are [less likely](#) to reenter treatment. For all inmates with OUD, incarceration without medication treatment increases risk of post-release overdose death through reduced opioid tolerance. Continuation of Medicaid coverage during detention and incarceration, or reinstatement of coverage prior to release, will facilitate treatment continuity and retention. Thus, ASAM is proud to support these bills, which would close a critical gap in access to care.

Conclusion

In conclusion, ASAM is actively building, implementing, and advocating for the tools and resources to secure a foundation for addiction treatment in this country that will save lives. To be truly effective, this requires an “all hands-on deck” approach by the medical community, payers, and policymakers to drive demand toward quality, evidence-based care.

As you can see, there isn’t a lack of good ideas, and we do know what to do to treat addiction and save lives. Sadly, to date, our nation hasn’t fully tackled the addiction and overdose crisis like the systemic problem that it is. We know that systemic change – disrupting the status quo that is falling short of our full potential – is exceptionally difficult and won’t happen overnight. But given the magnitude of the problem we face, it is both necessary and worth it to end this

suffering being experienced across our nation, in our communities, and by American families.

Thank you.

American Society of Addiction Medicine
11400 Rockville Pike Suite 200 Rockville, MD 20852
Phone: 301.656.3920 | Fax: 301.656.3815
www.ASAM.org