The National Center on
Addiction and Substance Abuse

February 16, 2018



The Honorable Orrin G. Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510-6200

Dear Senators Hatch and Wyden:

Thank you for the opportunity to provide comments to the Committee regarding federal policy options to address the opioid epidemic. We applaud the Committee for recognizing the need for policy recommendations that span a continuum from prevention to improving access to and quality of treatment.

The National Center on Addiction and Substance Abuse is a national, non-profit research and policy organization focused on improving the understanding, prevention, and treatment of substance use and addiction. Founded in 1992 by Joseph A. Califano, Jr., our Center has worked to improve public understanding of addiction as a disease and to connect the science of addiction with policy and practice. We have published seminal reports on a range of addiction-related topics, including:

- Evidence-based prevention and treatment strategies (*Addiction Medicine: Closing the Gap between Science and Practice*);
- A public-health approach to addiction (*Guide for Policymakers: Prevention, Early Intervention and Treatment of Risky Substance Use and Addiction*);
- Improving insurance coverage of addiction (*Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*)
- Teen substance use and addiction (*Adolescent Substance Use: America's #1 Public Health Problem*);
- Substance use in the criminal justice system (*Behind Bars II*); and
- The economic impact of addiction on federal and state budgets (*Shoveling Up II*).

As a leading voice for science-based policies, we have developed recommendations for nearly every audience – including parents, health care professionals, schools, the media, federal and state governments, the criminal justice system, and the general public.

Our Center also developed targeted resources to address the current opioid epidemic. To help facilitate the process of taking tangible and effective steps to address the opioid epidemic, we created a guide for Federal action, which we have attached to this letter. This set of recommendations presents concrete actions the Federal government can and should take to have a measurable impact on the crisis. We created a similar set of

recommendations for state policymakers (*Ending the Opioid Crisis: A Practical Guide for State Policymakers*). The detailed recommendations draw from years of our own work on this issue as well as other organizations with a deep interest in finding workable solutions to help end this epidemic. In all cases, the recommendations are based on research evidence and a health promoting rather than punitive approach to opioid misuse and addiction. These recommendations reflect the comprehensive approach necessary to effectively address the current opioid crisis and prevent future epidemics. In addition to these references, we provide feedback below on the specific questions posed by the Committee that are most relevant to our work.

***How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives or ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?***

Increase screening

Opioid and other substance use disorders (SUDs) occur along a continuum and, like other chronic diseases, patients benefit from early identification and treatment. Unfortunately, few individuals are screened for SUDs. Screening and early intervention should be provided in health care settings as well as other settings that have contact with individuals at high risk, including justice programs and educational and social service settings. The federal government should require that routine screening and brief interventions be provided by trained professionals in all agencies (health care, educational, mental health, developmental disabilities, child welfare, housing, juvenile justice, and adult corrections services) that receive public funding. Patients who screen positive for risky substance use or a potential diagnosis of addiction should be connected with a trained health professional for diagnosis, intervention, treatment, and disease management.

Emergency department initiated treatment

Individuals who experience an overdose or other injuries related to substance use often present at hospital emergency departments but leave without being appropriately connected to care. Because addiction affects the parts of the brain associated with self-care and decision-making, and patients' willingness to engage in treatment waxes and wanes, many patients do not follow-up on a referral for treatment. Additionally, overdose reversal precipitates painful withdrawal symptoms putting a patient at high risk for a subsequent overdose. Emergency department-initiated treatment is a promising strategy to address these issues, but is not widely available. The federal government should provide necessary incentives, such as increased reimbursement rates, to hospitals to encourage them to screen all patients presenting at the emergency department with a SUD and provide appropriate interventions – including medication-assisted treatment (MAT) – to those who screen positive, and develop a treatment plan and/or "warm hand-off" to a treatment program for each patient that screens positive.

Requirements to promote quality care

Most individuals who receive addiction treatment do not receive evidence-based care or do not receive it in sufficient intensity and duration to promote long-term recovery. Individuals with SUDs who receive inadequate care often relapse, which perpetuates the perception that addiction is untreatable.

*Increase access to Medication-Assisted Treatment*

Medication-Assisted Treatment (MAT) – the combination of psychological/behavioral therapy and FDA-approved medications (i.e., methadone, buprenorphine, naltrexone) -- is the most effective means of treating opioid use disorders and preventing opioid overdose.[1] MAT is also cost effective; every dollar spent on it realizes an estimated $1.80 in societal savings, including costs related to criminal activity and work productivity.[2] Despite its proven effectiveness, fewer than ten percent of patients with opioid addiction receive MAT.[3] Lack of access to effective treatment for opioid addiction is a major contributing factor to the opioid epidemic. The lack of availability of effective treatment for opioid use disorder is due, in part, to restrictive federal regulation on the delivery of these medications, which reduces their accessibility.

The current legal and regulatory framework around the delivery of MAT is rooted in stigma and a misunderstanding of addiction as a moral failing. MAT is a unique medical treatment in that it is highly regulated by the government. The requirement that methadone be delivered only in Opioid Treatment Programs (OTPs) and the limit on the number of patients who can be treated with buprenorphine are unique and not applicable to any other medications, including highly addictive opioids prescribed for pain. The origin of these laws and regulations can be traced back to the enforcement of the Harrison Narcotics Act of 1915 and the Supreme Court's ruling that maintenance is not a legitimate practice of medicine.[4] The federal OTP laws that govern methadone clinics were initially crafted to LIMIT access to methadone, based on the fear that methadone would promote violence, perpetuate opioid addiction, and encourage other socially unacceptable behaviors. More than 50 years later, we know the opposite to be true; methadone reduces opioid use and criminal behavior and stabilizes patients so they can lead productive lives. However, the requirement for patients to receive daily doses at methadone clinics is a significant barrier for patients seeking to treat their opioid dependence, impedes their re-entry into society, and unnecessarily perpetuates their sense of shame and stigma. The federal laws that govern the delivery of buprenorphine were also intended to LIMIT the number of patients who receive the medication and the number of doctors who can prescribe it because of the Federal government's concerns that buprenorphine prescribing could get "out of hand."[5] Once again, we know the opposite to be true; more than one million people who need this medication are unable to access it.[6]

These laws and regulations are intended to limit the use of these medications and the number of patients that receive them. The justifications for these restrictions are based on negative attitudes about individuals with addiction and distrust of medical professionals to appropriately treat them with opioid-based medication. This is based on stigma, fear and anecdote; not science. As a consequence, our health care system is woefully unequipped to treat and manage this disease.

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[1] Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2014). Medication-assisted therapies--tackling the opioid-overdose epidemic. *New England Journal of Medicine, 370*(22), 2063-2066.
[2] Institute for Clinical and Economic Review. (2014). *Management of patients with opioid dependence: A review of clinical, delivery system, and policy options.* Retrieved from https://icer-review.org.
[3] Nosyk, B. A., Brissette, S., Kerr, T., Marsh, D. C., Schackman, B. R., Wood, E., et al. (2013). Analysis & commentary: A call for evidence-based medical treatment of opioid dependence in the United States and Canada. *Health Affairs, 32*(8), 1462-1469.
[4] Webb v. United States, 249 U.S. 96 (1919).
[5] Jaffe, J. H. & O'Keeffe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug & Alcohol Dependence 70*, S3–S11.
[6] Jones, C. M., et al. (2014). National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health, 105*(8), e55–e63.

We encourage the Federal government to closely examine the existing legal and regulatory framework around the delivery of MAT and change it to meet the goal of enhancing access to these life-saving medications. This cannot be achieved by continuing to build upon, or tinker around the edges of, a framework meant to limit access to these medications. The stigma must be rooted out and any restrictions on the delivery of these medications must be based on science and evidence. The Federal government can take the lead in changing negative attitudes about addiction and treatment for opioid addiction by eradicating the pervasive stigma underlying the laws and regulations that govern how we treat this disease.

*Integrate addiction treatment with mainstream health care system*

Historically, the addiction treatment system has been marginalized and not well integrated with the mainstream health care system. As a result, addiction care has not benefited from the medical advancements that have improved the quality of care and treatment of other chronic diseases. Further, addiction treatment providers are not subject to the same level of regulatory oversight as other health care providers. To improve the quality of the addiction treatment system, it needs to be well integrated with the health care system, including being subject to oversight by the agencies responsible for regulating health care facilities. Such integration will also help improve the treatment of other health conditions. Individuals with addiction often suffer from co-occurring mental and physical health conditions, which need to be treated concurrently with addiction, typically via a medical approach, to achieve the best and most sustainable outcomes. Yet, as of 2016, only 50 percent of addiction treatment facilities provided comprehensive mental health assessments and diagnoses. Several concrete steps can be taken to improve the quality of addiction care in the U.S.:

- As a condition of receipt of public funds, the federal government should require that facilities that provide addiction treatment services utilize evidence-based approaches and employ a multidisciplinary team of health professionals, along and individuals in recovery, to provide support services. The government should increase funding/reimbursement so that facilities can provide such services.

- As a condition of reimbursement, contracts between public insurers and treatment providers should require that treatment be provided, supervised, or managed by qualified health care professionals; that providers utilize evidence-based addiction care services; and that treatment facilities generate positive and measurable patient outcomes.

- Encourage integrated care for mental health, SUDs and physical health and remove any legal or regulatory requirements that create barriers to integrated treatment.

- Expand the use of Medicaid health homes to provide comprehensive care coordination for Medicaid/Medicare beneficiaries with chronic health conditions, including SUDs.

- To identify the appropriate treatment setting for a patient, experts have developed scientifically validated patient placement tools to assist treatment programs, government programs, insurers, and other organizations in appropriately matching patients' needs to specific treatment services and to determine the appropriate level of care (e.g., inpatient, outpatient, residential).

The American Society of Addiction Medicine (ASAM) developed the ASAM Criteria, which contain guidelines for patient placement and define services and levels of care. The New York State Office of Alcoholism and Substance Abuse Services (OASAS), in collaboration with our Center, developed the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR), a web-based tool that determines the most appropriate level of care using factors such as patient risk factors and resources. The federal government should require the use of such tools, as a condition of reimbursement for Medicaid and Medicare beneficiaries, to help ensure that patients receive the appropriate level of care that will meet their treatment needs.

Change the current reimbursement system

The current fee-for-service insurance reimbursement system does not create incentives for high quality treatment. As the entire health care system moves toward value-based care, new reimbursement methodologies are needed. Value-based models, in which billing and payments are determined on the basis of outcomes achieved rather than services rendered by a health care provider, reflect fairer compensation for addiction treatment services and can incorporate accountability for providing quality care.

There is great hope that alternative payment models will improve access and quality of care for substance use disorders. However, there is reason for caution in setting up the structure for these new models. The limited studies or evaluations specifically examining the impact of financial incentives have yielded mixed results. Incentive programs will be challenging for the addiction treatment industry because it is disconnected from general medicine and its workforce lacks knowledge about business strategies and models of care that are integrated with medicine. The federal government should adopt value-based methodologies in Medicare and Medicaid and incorporate addiction treatments into these payment arrangements but, any new incentive program should attend to the following three factors: 1) need for more performance measures that capture quality care for SUD; 2) incentives need to be sufficient to reward medical providers for investing in SUD treatment capacity; and 3) both medical and SUD treatment providers need training and support for clinical practice change.

- **Performance measures.** Quality metrics are an essential component of alternative payment models based on value but there are insufficient measures that adequately assess quality care for SUD. Measurement development for SUD has had a later start than for other medical conditions. The development and acceptance of performance measures is laborious and follows a long timeline. Consequently, greater priority and resources are needed for development and vetting of new measures. Currently, the measures in the pipeline are focused on access to treatment among those diagnosed, early transitions in care for those in acute care (emergency departments, hospitalizations), and use of approved medications. More work is needed to finalize some of the measures still under development (e.g., medication use) as well as of other measures that assess patient outcomes.

- **Adequate incentives.** Currently, payment rates for screening, brief interventions, and treatment are not sufficient to entice medical providers to take on programs like SBIRT (screening, brief intervention, referral to treatment) despite multiple recommendations and support from SAMHSA. For medical and SUD providers to make the requisite investments in time, workforce

development, and technology to better integrate care, the remuneration will need to be higher than what is currently available.

- **Provider training and technical assistance.** In addition to performance measures and stronger incentives, medical and SUD treatment providers will need additional supports to guide development of integrated care. Providers, particularly SUD providers, will need help in restructuring their practices to survive with new alternative payment structures. They will need guidance on business practices that range from revenue cycle management to the use of data to drive clinical care. Additionally, both medical and SUD programs need technical support in implementing care for SUD within their practices.

***What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts and incorporated into Medicare?***

Below are some specific examples of state programs that employ the aforementioned recommendations.

- Rhode Island's Centers of Excellence (COE) help individuals with addiction access comprehensive treatment in a timely manner. The COEs, which are certified by the state, provide evaluations, treatment, and referrals. The COEs' multi-disciplinary staff provides patient-centered care. They can provide FDA-approved medications on-site and serve as a resource for community-based providers.

- Vermont's Care Alliance for Opioid Addiction employs a "Hub and Spoke" model, which focuses on expanding access to MAT for individuals with an opioid use disorder while also creating a framework for integrating treatment services through a managed care approach. The model is comprised of "hubs" -- methadone treatment programs, and "spokes" -- a team of outpatient providers that prescribes buprenorphine. The hubs and spokes also provide home health care services to patients, including clinical care coordination. This model increased the state's capacity to provide MAT by more than 40 percent from January 2013 through July 2014, and helped to retain patients in treatment.[7]

- Virginia has a comprehensive 1115 waiver, Addiction Treatment Services Delivery System Transformation. Under the waiver, Virginia aligned its definitions of community-based treatment services with the ASAM Criteria and required use of the ASAM Criteria by Medicaid providers, managed care plans and behavioral health organizations when completing assessments, determining the appropriate level of care, and making recommendations for residential treatment length of stay. Virginia also increased its Medicaid reimbursement rates for addiction treatment to align with the reimbursement rates set by commercial insurers. The Department of Medical Assistance Services collects data from Medicaid managed care and behavioral health organizations on addiction treatment quality measures, which are used to improve quality processes.

[7] Vermont Department of Health, Vermont Agency of Human Services. (2015). *The opioid addiction treatment system*. Retrieved from http://www.leg. state.vt.us.

- New York State is transitioning its behavioral health services from a fee-for-service to a Medicaid managed care payment structure.[8] The redesign focuses on integrating physical and behavioral health. In connection with this transition, New York is adopting a set of financial reforms within its Medicaid program to spur improvement in care for those with SUD. Along the way, it has also put into place a set of protections so that patient get good quality care and the SUD treatment system can weather the changes in revenue and other business practices that are accompanying the reforms. Much as in the rest of the country, the treatment system has a mix of providers that range in size and organizational sophistication, with a significant proportion having limited financial reserves and workforce with strong business skills. New York intends to strike a balance between using new financial mechanisms to spur improvements in care while ensuring that the existing system of care does not collapse. The recent New York changes have included carving the behavioral health benefit into mainstream managed care and a structured process toward introducing value-based contracting within Medicaid. Along with these changes, the state introduced the following mechanisms to protect quality care:

    - Developed a standardized level of care tool determination tool (LOCADTR) that protects patients by increasing transparency in the decision-making between providers and health plans. The tool was developed using evidence-based clinical decision criteria and in a manner that is easy for providers and plans to use.
    - Developed a continuing review tool that allows providers and plan to discuss both whether a patient should stay within a current setting and whether the patient is getting quality care during the treatment episode.
    - Technical assistance to help providers navigate and build new business practices (e.g., revenue cycle management, billing) for managed care and value-based purchasing and to develop new clinical care models that better align with these new financing models. New York state-based partners, including our Center, provide technical assistance and learning communities to behavioral health agencies to ensure that providers have the necessary tools and knowledge to successfully transition to the new system.[9]

- California's Medicaid 1115 waiver (Medi-Cal 2020) includes the Drug Medi-Cal Eligibility and Delivery System, a pilot program available to counties seeking to provide evidence-based and integrated care to beneficiaries with addiction, including a continuum of care modeled after the ASAM Criteria.[10]

- Massachusetts' Medicaid 1115 waiver (MassHealth) expands treatment services for individuals with addiction, including home- and community-based services, residential services, and recovery support services.[11]

- Yale Hew Haven Hospital launched an innovative buprenorphine program to initiate treatment for opioid addiction in the emergency department (ED),

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[8] New York State Department of Health. (2017). *Behavioral health transition to managed care: Overview and background*. Retrieved from https://www.health.ny.gov.
[9] Community Technical Assistance Center of New York. (2017). *Effective care: Efficient practices: Who we are*. Retrieved from http://www.ctacny.org.
[10] California Department of Health Care Services. (2012). *California Medi-Cal 2020 Demonstration*. Retrieved from http://www.dhcs.ca.gov
[11] Centers for Medicare and Medicaid Services. (2016). *MassHealth Medicaid § 1115 demonstration*. Retrieved from Massachusetts Department of Health and Human Services website: http://www. mass.gov.

following an overdose, instead of providing a referral to treatment. The Yale team provides brief counseling, buprenorphine and connects patients to primary care following an overdose.[12] Patients initiated on buprenorphine in the ED and who continued to receive buprenorphine in a primary care setting were significantly more likely to remain in treatment than those who only received a brief intervention or referral to treatment in the ED.[13]

***What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children or families?***

Parent-focused prevention:

The undeniably best way to avoid the costly consequences of opioid misuse and addiction is to invest in effective prevention and early intervention to reduce its incidence. Effective prevention is comprised of public education and awareness that helps to reduce the appeal of addictive substances; evidence-based addiction prevention programming; and laws, regulations, and policies that reduce the availability and accessibility of opioids and other drugs, particularly to young people. The use of screenings and early interventions to identify individuals who are at risk for or already using addictive opioids is essential for preventing opioid misuse from progressing to addiction. Parents are on the front lines and are most influential in preventing youth substance use. Therefore, resources must be allocated to educating parents about opioid misuse and addiction and about how to help ensure that their children do not go down the dangerous path of addictive substance use.

*Home visiting programs*

Home visiting, a strategy for delivering voluntary preventive services aimed at optimizing parent and child outcomes across the life course, is the primary supportive intervention offered to at-risk families during the perinatal period.[14] Services vary across home visiting models and may include: teaching parenting skills, promoting early learning and school readiness, educating parents on child development, providing social support, screening for developmental risk, and providing referrals for education, employment, health, and mental health services. Depending on the model, home visiting may begin prenatally or within the first year after birth and extend until the child is three to five years old. Thus, home visiting programs are well-positioned to intervene in families to prevent negative outcomes during the critical early years of development. Twenty home visiting models serving families prenatally through age five are currently designated as evidence-based, with favorable impacts on a host of outcomes related to child and maternal health, school readiness, child maltreatment reduction, and parenting.[15]

In 2012, the Maternal Infant and Early Childhood Home Visiting program (MIECHV) was established under the Affordable Care Act to support states in expanding their capacity to

[12] Kashef, Z. (2017). Yale faculty lead a four-city effort to study best practices for opioid addiction. *YaleNews* Retrieved from https://news.yale.edu.
[13] D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., et al. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA*, 313(16), 1636-1644.
[14] Minkovitz, C., O'Neill, K., Duggan, A. (2016). Home visiting: A service strategy to reduce poverty and mitigate its consequences. *Academic Pediatrics, 16*, S105-S111.
[15] Sama-Miller, E., Akers, L., Mraz-Esposito, A., Zukiewicz, M., Avellar, S., Paulsell, D., & Del Grosso, P. (2017). *Home visiting evidence of effectiveness review: Executive summary*. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. DHHS. Washington, DC.

deliver evidence-based home visiting to high-risk families. Since the start of MIECHV, the federal government has invested nearly $2.7 billion in home visiting.[16] This funding resulted in significant scale-up of home visiting across the country; evidence-based home visiting programs now operate in all 50 states, the District of Columbia, and five territories, and serve more than 160,000 of the highest risk families annually, representing a nearly five-fold increase since MIECHV began.[17] MIECHV was just re-authorized for another five years, which will likely increase the number of families reached by home visiting.

Home visiting is a promising venue for reaching substance using pregnant and postpartum women. Nationally, nearly 40% of home visiting clients report binge drinking or drug use in the three months prior to enrollment in home visiting.[18] While specific data on opioid use among home visiting clients is not available, home visiting is well-positioned to be part of the nation's response to the opioid epidemic.[19] Home visiting is specifically mentioned in the *Protecting Our Infants Act* as a key component of discharge planning for infants with neo-natal abstinence syndrome (NAS), and is also part of states' planned implementation of the Plan of Safe Care for substance-exposed infants mandated under the *Comprehensive Addiction and Recovery Act.* The immediate postpartum period is a particularly important time for preventing relapse, and home visiting often represents vulnerable families' only contact with the formal service system during this time.

Below are some examples of home visiting programs:

- In partnership with state agencies in New Jersey, our Center developed and tested strategies to identify substance use, depression, and domestic violence among pregnant and postpartum women enrolled in home visiting programs, and to improve their access to treatment. We recently completed a pilot test of our program in four programs with 25 home visitors, four supervisors, and 121 clients.[20]

- South Carolina's Nurse-Family Partnership Program

- Massachusetts developed a new Head Start initiative specifically for infants with opioid-addicted parents.

Treatment for parental substance use:

*Prenatal Care*

[16] First Focus (2015). *The maternal infant and early childhood home visiting program: A smart investment in the future of children*. Retrieved from https://firstfocus.org/resources/fact-sheet/the-maternal-infant-and-early-childhood-home-visiting-program-a-smart-investment-in-the-future-of-children.
[17] Health Resources and Services Administration. (2016) *The Maternal Infant and Early Childhood Home Visiting Program: Partnering with parents to help children succeed.* Washington, DC: HRSA.
[18] Michalopoulos, C., Lee, H., Duggan, A., et al. (2015). *The Mother and Infant Home Visiting Program Evaluation: Early findings on the maternal, infant, and early childhood home visiting program.* Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. DHHS.
[19] Home Visiting Policy Network (2018). *MIECHV reauthorization: Combating the opioid epidemic through evidence-based home visiting*. Washington, DC: The Dalton Daley Group.
[20] Dauber, S., John, T., Hogue, A., Nugent, J., & Hernandez, G. (2017). Development and implementation of a screen-and-refer approach to addressing maternal depression, substance use, and intimate partner violence in home visiting clients. *Children and Youth Services Review, 81*, 157-167.

It is essential to provide comprehensive prenatal care and addiction treatment for pregnant women with SUD to prevent neo-natal abstinence syndrome (NAS) and improve outcomes for children born with NAS. Recent research suggests that pregnant women who are addicted to opioids should be treated with medication-assisted treatment, which utilizes methadone or buprenorphine in conjunction with counseling. Although the use of such medications during pregnancy may cause NAS, it can be managed with effective neonatal care and treatment at birth and is not associated with harmful long-term outcomes for the child. Stopping opioid use and precipitating withdrawal is not recommended during pregnancy as it increases the risk of miscarriage. We must expand access to addiction treatment and social supports for reproductive-age women (focusing on pregnant and postpartum mothers). Addiction treatment should be a standard part of prenatal care; unfortunately, most obstetricians are ill-equipped to address it and treatment options for pregnant women are extremely limited.

Many pregnant women who use substances do not access basic prenatal care due to the stigma surrounding drug use during pregnancy and the fear of being reported to child protective services. Most women who use substances during pregnancy do not engage in such behavior willfully or because they act in self-interest and disregard; but rather because they suffer from addiction. Nonetheless, women who use drugs during pregnancy are presumed to be neglectful or abusive. This presumption underlies the widespread use of punitive measures, such as criminalization and the engagement of child protective services, as the primary response to substance use in pregnant and postpartum women. Such measures are incongruent with the science of addiction and serve to punish rather than treat women for their addiction.

After birth, mothers need continued support and treatment to achieve or maintain recovery and address any mental health, environmental or other challenges that may put them and/or their children at risk. There is a pressing need for more coordinated, integrated services for mothers and infants. Research has shown that outcomes are better for both mothers and children when they are treated in programs that provide comprehensive, integrated services that address substance use and parenting concerns.

*Child welfare engagement*

Services should also be provided to families with parental substance use, beyond the perinatal period, with the goal of providing treatment to parents and keeping the family together. The current opioid epidemic is resulting in numerous referrals to and removals by the child welfare system. The primary purpose of the child welfare system is to investigate reports of abuse and neglect and child welfare workers often lack the appropriate training and resources to effectively address substance use disorders. Given that the magnitude of the current epidemic is overwhelming an already strained system, more research and resources are needed to help the child welfare system facilitate linkages to treatment and promote recovery for mothers with addiction.

One promising program is the Sobriety Treatment and Recovery Team (START) program, which provides services to families with parental substance use who have been referred to child welfare services. Social workers provide peer support and facilitate treatment and recovery services with the aim of keeping the family together. The program has demonstrated promise in helping mothers achieve sobriety, keeping families together, and cost-effectiveness. The program is expanding to pilot sites in other states.[21]

[21] Addiction Policy Forum. (2017). *Focus on innovation: Sobriety Treatment and Recovery Teams (START)*. Retrieved from http://docs.wixstatic.com.

Thank you for your willingness to receive our comments. While addiction has long been a national problem and our Nation has faced other drug epidemics, the current opioid crisis is the deadliest. We need to immediately adopt interventions to drastically reduce the number of overdose deaths. But we must also recognize that this epidemic took hold because we lack both a national prevention strategy to discourage our children from using and misusing addictive substances and a well-regulated treatment system equipped to provide evidence-based care to those suffering from addiction.

The desire to punish those who use drugs led us to rely on ineffective scare tactics for preventing substance use and to commit scarce resources to criminal justice interventions rather than ensuring that our health care system was prepared to treat the disease of addiction. The shame and stigma surrounding addiction have long undermined our efforts to implement effective policies to address this public health crisis.

We urge Congress to act quickly and to commit the resources necessary to address the scope of this crisis. We cannot wait for further study or recommendations to address this problem. We know how to fix it and we desperately need our Federal government to act. American lives are at stake.

Thank you for your continued leadership to help our nation overcome this crisis. We are prepared to offer any assistance that may be needed, given our extensive expertise in this area.

Sincerely,

Creighton Drury
President

# Guide for Federal Actions to Prevent Opioid Misuse and Addiction

## 1. Develop, Fund, and Implement Effective Public Education and Awareness Campaigns

- Develop prevention campaigns based on effective messaging and evidence-based prevention strategies
- Information campaigns should inform the public about:
  - Opioid addiction and how best to identify, prevent, and treat it.
  - How to access quality addiction care services.
  - How to safeguard controlled prescription medications from children and adolescents.
  - How to dispose properly of unused controlled prescription medications.
- Frame addiction as a chronic medical disease for which there are effective treatments, including medication and behavioral therapies.
- Design campaigns to reduce the stigma of addiction and its treatment.
- Identify the most pressing or emerging issues and target informational campaigns accordingly.
- Create targeted campaigns to protect the safety of people who already misuse opioids.
- Evaluate the impact of all campaigns and adjust the messaging and implementation accordingly.

## 2. Develop, Fund, and Implement Effective School- and Community-Based Prevention

- Require schools and communities to deliver evidence-based prevention that is health based and not punitive.
- Address both prescription and illicit opioid misuse as well as co-occurring health conditions.
- Include a special focus on children and adolescents who are most vulnerable to opioid misuse.
- Screen all young people for signs of risk, provide effective intervention services to those identified as being at risk, and refer to treatment those who may have an opioid use disorder (i.e., conduct screening, brief intervention, and referral to treatment, or 'SBIRT').
- Adequately fund prevention programs, including funding for evaluation of programs.

## 3. Reduce the Availability of and Accessibility to Opioids

- Promote the adoption of standardized Prescription Drug Monitoring Program (PDMP) systems that would allow for interstate collaboration and data sharing, which are essential for preventing diversion and misuse.
- Provide financial incentives and technical support for states to develop and operate PDMPs in accordance with national standards.
- Ensure that PDMPs protect patient privacy, allow physicians and pharmacists access to patient data, provide law enforcement officials with access based on probable cause, and stipulate specific outcome measures to determine the efficacy of state programs.
- Require that all Medicaid Part D plans include a prior authorization requirement stating that prescribing physicians must attest to having checked the state PDMP prior to prescribing any controlled prescription opioid medication.
- Require that, as a condition of becoming registered by the Drug Enforcement Administration (DEA) to prescribe or administer controlled medications, physicians demonstrate competence in proper treatment of pain, prescribing controlled substances, recognizing the signs and signals of misuse or diversion, and knowing how to respond in the event of suspicion of misuse or diversion.
- Prohibit direct-to-consumer advertising of controlled prescription drugs.

- Prohibit sale or purchase of controlled prescription drugs on the Internet without an original copy of a prescription issued by a licensed DEA-certified physician, licensed in the state of purchase, based on a physical examination and evaluation.

### 4. Invest in Research

- Conduct/fund research to help develop non-addictive pain treatments.
- Conduct/fund research on new treatments for opioid addiction and treatment for pregnant women and babies born with neonatal abstinence syndrome.
- Accelerate data collection and dissemination on opioid misuse, addiction, overdose, and consequences to facilitate more frequent and timely statistical reports on trends and populations and locations at high risk.
- Conduct/fund research on the effectiveness of PDMPs and optimal use of the data collected.
- Conduct/fund research to evaluate treatment approaches for parolees and probationers to help determine whether addiction-related interventions are delivering their intended results for justice-involved individuals.

## Reduce Overdose Deaths and Other Harmful Consequences

### 1. Increase Access to Naloxone

- Require states, as a condition of receiving federal funding, to mandate that every first responder be trained to administer naloxone and provided with a supply of the medication.
- Use federal purchasing power to help drive down the cost of naloxone.
- Make naloxone an over-the-counter medication.
- Provide model legislation for states to allow the dispensing of naloxone through standing orders and to require the prescribing of naloxone along with prescriptions for all controlled opioid medications.
- Require health plans under federal jurisdiction to cover naloxone with minimal utilization requirements and cost-sharing.

### 2. Fund Enhanced Monitoring and Tracking of New and Emerging Synthetic Opioids

- Create national standards for monitoring and tracking new and emerging synthetic opioids (“drug checks”) to facilitate data collection and rapid data sharing within and among States.

## Improve Opioid Addiction Treatment

### 1. Improve Providers’ Knowledge and Clinical Practice

- Expand the addiction medicine workforce by increasing the availability of addiction medicine training programs.
    - Allocate a designated portion of the federally funded (primarily through Medicare) medical residency training positions to residency training in the specialties of addiction medicine and addiction psychiatry.

- Allocate residency training slots through the U.S. Department of Veterans Affairs and the Indian Health Service to addiction medicine to help ensure the availability of specialty care for veterans and Native Americans.

- Establish national standards for educational curricula, licensing, and certification requirements that include core clinical competencies in addiction care for health care providers, including physicians, physician assistants, nurses and nurse practitioners, dentists, and clinical mental health professionals (psychologists, social workers, therapists, counselors).
- Require medical and nursing schools that receive federal loans to provide comprehensive addiction care education and training.

## 2. Improve Access to Quality Treatment and Disease Management

- Require insurance coverage for comprehensive addiction care, including all forms of medication-assisted treatment (MAT), with minimal utilization requirements and cost sharing.
    - Require all federally funded insurance programs, including Medicaid, Medicare and VA/TRICARE, to include comprehensive benefits for addiction care -- including patient education, screening, assessment, intervention, treatment, and management -- without limitations or exclusions.
    - Enforce the provisions of the Patient Protection and Affordable Care Act (ACA), which require covered plans, as part of the Essential Health Benefits package, to offer addiction services.
    - Enforce the provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),which require insurance benefits for mental health and addiction care to be offered on par with coverage for medical and surgical benefits. The Department of Labor and the Internal Revenue Service are responsible for enforcing MHPAEA in private employer-sponsored group health plans; the Department of Health and Human Services is responsible for enforcing MPHAEA in non-federal government health plans. Insurance regulators should be required to levy penalties against health plans that violate MHPAEA.
- Expand access to medication-assisted treatment (MAT) for opioid addiction by eliminating barriers to providers for prescribing effective medications:
    - Remove the limits set for physicians on the number of patients they can treat with buprenorphine and the eight hours of training required to prescribe the medication. Such limits do not exist for physicians to prescribe the opioid medications to which patients have become addicted in increasing numbers.
- Eliminate barriers to treatment throughout the states resulting from the federal Institutes for Mental Diseases (IMD) exclusion within the Medicaid program. This component of the Social Security Act prohibits federal Medicaid funds from being used to reimburse services provided in an inpatient facility that has more than 16 beds from treating “mental diseases” (including substance use disorders).
- Require all facilities and programs providing addiction treatment to adhere to established national minimum standards for accreditation as a condition of licensure.
- Establish national licensing and accreditation standards for addiction treatment facilities and programs that reflect evidence-based care. While the federal government does not regulate addiction treatment facilities or programs (with the exception of opioid treatment programs), it does impose certain conditions through the federal health insurance programs.
    - Subject all addiction treatment facilities and programs to the same mandatory licensing processes as other health care facilities.

- Encourage coordinated care of co-occurring conditions by dually licensing qualified addiction treatment facilities to provide both mental health and addiction treatment services.
- Require addiction treatment programs to seek accreditation from one of the national accrediting organizations: The Commission on Accreditation of Rehabilitation Facilities, The Joint Commission, The Council on Accreditation, The National Committee for Quality Assurance or The National Commission on Correctional Health Care.

## Provide Opioid Addiction Care in the Criminal Justice System

### 1. Implement Comprehensive, Evidence-Based Addiction Care Services

- Condition federal funding for treatment provided within the federal criminal justice system on the implementation of comprehensive, evidence-based services, including medication-assisted treatment (MAT).
- Require agencies that receive federal grants, such as Second Chance Act grants which provide funding for agencies to improve the lives of those re-entering communities after incarceration, to provide evidence-based treatment or refer individuals to treatment providers that offer evidence-based services.
- Ensure that policies around relapse for drug court participants and individuals formally incarcerated are not punitive, but rather treatment-focused and responsive with increased intensity of treatment, monitoring, and supervision.

### 2. Remove Restrictions on Needed Services for Individuals in the Criminal Justice System

- Eliminate the federal policy in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that bans individuals with drug felony convictions from receiving federal benefits such as Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps) and other benefits (e.g., public housing, education assistance). Such policies create barriers to recovery.