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February 16, 2018

Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senators Hatch and Wyden:

We greatly appreciate the Committee's decision to focus on opportunities to improve our nation's response to the opioid epidemic.

Alkermes is a global pharmaceutical company working to address the unmet needs and challenges of people living with debilitating diseases. Alkermes is specifically focused on diseases of the central nervous system (CNS), including addiction. Alkermes manufactures and markets VIVITROL® (naltrexone for extended-release injectable suspension for the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with VIVITROL, and for the prevention of relapse to opioid dependence, following opioid detoxification.[1]

Since introducing VIVITROL as a treatment option for opioid dependence in 2010, we have worked with many treatment providers in an effort to understand the challenges they face, and the successes they have experienced, in their professional efforts to help people who have opioid dependence. As an organization, we have a deep commitment to understanding the experiences of patients and families that have been directly affected by opioid addictions, and to support patient access to the care that is most appropriate for them. Finally, as a company with approximately 2,000 employees, we also have a very personal stake in seeing this epidemic end,

[1] Please see Prescribing Information and Medication Guide for important product safety information at: https://www.vivitrol.com/.

as far too many of our employees' loved ones have been personally impacted by the worsening opioid crisis. The following comments are based on this collective experience and our firm commitment to pursue solutions.

Comments on the Committee's Deliberations:

1. ***How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing opioid use disorders (OUDs) or other substance use disorders (SUDs)?***

Comment – The U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) issued a national *Guideline for Prescribing Opioids for Chronic Pain* in 2016.[2] As the Committee is undoubtedly familiar with these recommendations from the CDC, we will not review them here. However, given the rigorous process upon which CDC relied in order to develop its recommendations, and the extensive input sought from a wide range of experts and other stakeholders, we encourage the Committee to consider using the *Guideline* as a foundation for its deliberations concerning possible changes to the Medicare and Medicaid programs' approaches to the management of pain, including changes that would promote coverage of and access to CDC-recommended therapies and services for pain management. In this regard, then, the Committee should encourage the Centers for Medicare and Medicaid Services (CMS) to work closely with the leadership of the CDC to identify the most promising means of changing the management of pain and approaches to opioid addiction treatment at both institutional and practitioner levels. Through the issuance of guidance, rules and special initiatives, CMS should incentivize full implementation of the recommendations for the management of pain in accordance with the CDC's *Guideline*. Moreover, given the ongoing public health emergency,[3] CMS should consider whether it can hasten its implementation of policy changes in light of the urgency of the situation. As recommended by the CDC's *Guideline*, CMS should evaluate how to: a) prioritize non-opioid alternatives in the management of pain; b) where opioids are medically necessary in order to manage pain, encourage the use of the lowest effective dose of opioids; c) encourage tapering patients off of opioids whenever medically appropriate; and d) discontinue the use of opioids altogether whenever medically appropriate.[4] We urge the Committee to ensure that Medicare and Medicaid payment policies

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[2] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1. Accessed online: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm#suggestedcitation.

[3] U.S. Dept. of Health & Human Services. (Oct. 26, 2017). *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis* [Press release]. Accessed online: https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html.

[4] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*, 2016; 65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1, page 16.

are designed in a manner that will encourage full implementation of the pain management recommendations set forth in the CDC *Guideline*.

2. ***What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?***

Comment – As noted above, the CDC has completed a timely and thorough review of the evidence with respect to non-pharmacologic therapies for chronic pain, and has published its findings in its *Guideline*. The Committee should encourage leadership within CMS to work closely with the CDC in ensuring appropriate coverage of and access to the most promising non-pharmacologic therapies for pain management. This can be done by creating or refining incentives for the use of such non-pharmacologic best practices when medically appropriate, as recommended by the CDC *Guideline*. In addition, we encourage the Committee to consider whether a public awareness campaign might also provide a second point of influence on current chronic pain management practices and the prescribing of opioids. The expectations of patients and families with respect to opioid prescribing and pain management need to change. In particular, patients and families need to develop a greater understanding about the significant risks of over-prescribing, as well as the potential effectiveness of non-opioid and non-pharmacologic therapies in managing chronic pain.

3. ***How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and SUD while promoting efficient access to appropriate prescriptions?***

Comment – As the treatment of OUD is within Alkermes' particular area of expertise, we have six specific recommendations for the Committee to consider.

First, based on our 12+ years of experience in the field of treatment of SUDs, we have learned that the treatment of OUD and other SUDs is unique in medicine in that providers rarely, if ever, utilize medications when reimbursement for the medication is limited to a medical benefit.

Addiction providers resist prescribing specialty medications for which reimbursement is limited to a medical benefit because the prescriber must first purchase the medicine, and then later seek reimbursement from the payer – a process that is sometimes referred to as "buy and bill." While medications reimbursed as a medical benefit are utilized in other medical specialties, such as oncology, OUD providers are not comfortable relying on reimbursement under a medical benefit. In our discussions with providers, we have repeatedly heard providers say they fear that, under "buy and bill," if they use the medication they will not get reimbursed – thus leaving them to absorb the cost of unreimbursed treatment. As further evidence of this fact, we have attached an example of a letter from the American Society of Addiction Medicine

(ASAM) written to state Medicaid plans (e.g. Minnesota, letter attached). ASAM has states that "[r]*emoving this Medicaid* [*buy and bill*] *requirement will ensure access to all FDA-approved medications for patients in Minnesota, so they can receive the right care they need when they need it"* (emphasis added). In short, removing requirements that limit Medicare and Medicaid coverage of OUD medications to a medical benefit and providing coverage under the pharmacy benefit will make it more feasible for OUD providers to offer specialty medications to Medicare and Medicaid beneficiaries.

Unfortunately, even when designated as a pharmacy benefit there are barriers to patient access. Injectable medications are subject to the "5i rule," which imposes additional rebate liability on a manufacturer whenever more than 30% of the drug prescriptions are filled in retail pharmacies (instead of the specialty pharmacies as is the custom under the medical benefit).[5] As a result, this rule can unintentionally create a nearly insurmountable disincentive to the development of injectable medications for OUD and other SUDs. It also places manufacturers of these types of OUD treatments at a disadvantage when the medications are utilized by Medicaid beneficiaries. This clearly runs counter to the public good and the intentions of the Committee, CMS and HHS. **Consequently, we ask the Committee to implement policies that will carve out all injectable medications for the treatment of OUD and other SUDs so that they are no longer subject to the 5i rule and associated financial penalties.**

Second, we encourage the Committee to review and potentially increase reimbursement rates to primary care and specialty providers that provide the full range of OUD and SUD treatment services – including screening, residential detoxification, residential rehabilitation, medication induction (opioid antagonists and agonists), counseling and telemedicine. Reimbursement for provision of these services should appropriately reflect the challenges associated with delivering comprehensive care to this complex and highly vulnerable population.

Third, the Medicaid Institutions for Mental Diseases (IMDs)[6] exclusion restricts payment for residential detoxification and rehabilitation and, as such, is a significant barrier to ensuring appropriate availability of these levels of care. We strongly encourage the Committee to explore ways to eliminate this obstruction to care for individuals with OUD and other SUDs. We also note the importance of ensuring appropriate access to other services such as relapse prevention and medications. There is a very high risk for relapse when detoxification is not followed by a significant course of treatment that helps to prevent relapse.[7,8] Consequently, detoxification in hospitals, jails, residential treatment programs, recovery housing or any other setting should always be followed by relapse prevention counseling and medication. Following

[5] 42 CFR §447.507.
[6] 42 USC §1396d.
[7] For example, see: PCSS-MAT "Management of Opioid Withdrawal and Overdose." Accessible at: https://pcssmat.org/management-of-opioid-withdrawal-and-overdose/.
[8] Smyth, Bobby P., et al. Lapse and relapse following inpatient treatment of opiate dependence. *Ir Med J.* (2010). 103 (6):176-9

detoxification, there are severe potential consequences associated with relapse, specifically the potential effects of overdose. Every effort should be made to build on the progress made during detoxification and rehabilitation by ensuring access – and appropriately incentivizing – the delivery of relapse prevention counseling and medications. **Consequently, we strongly encourage the Committee to increase the availability of detoxification and rehabilitation services through removal of the IMD exclusion for treatment of OUD and other SUDs. Relatedly, we urge the Committee to promote coverage and payment policies that strongly incentivize the provision of relapse prevention counseling as well as medications approved by the FDA for the prevention of relapse following detoxification.**

We also encourage the Committee to engage in the establishment of reimbursement for protocols used to assess whether certain patients who are currently prescribed opioid therapies for their chronic pain can be successfully detoxified and transitioned to non-opioid alternatives that can help offer them a better quality of life . The Committee should consider policies that provide reimbursement for protocols in which qualified practitioners will: a) successfully detoxify patients off of opioid therapy for chronic pain, to an opioid-free state; and b) where medically appropriate, allow such patients' pain conditions to be successfully managed with non-opioid and non-pharmacologic alternatives. Certain patients currently on chronic opioid therapy can be successfully detoxified and returned to an opioid-free condition, with a concomitant improvement in their quality of life. [9] However, it is unclear whether current reimbursement is sufficient to support qualified practitioners in completing this type of procedure.

Relatedly, it is important for the Committee to take into account a condition known as "opioid induced hyperalgesia" (OIH) which occurs when a patient's pain actually ***worsens*** because of long-term opioid use. [10, 11] There is a growing consensus that OIH has been an inadequately appreciated phenomenon which, when properly identified and addressed, can reduce the incidence of disability and pain, as well as unnecessary costs. [12, 13] The medical community does not yet fully understand the prevalence of OIH and related conditions, but it seems increasingly likely that many patients on long-term chronic opioid therapy for pain could be successfully detoxified and able to achieve remission from their pain condition by stopping the use of all opioids. However, there needs to be a clear pathway for qualified clinicians to be appropriately reimbursed for this type of procedure. **We encourage the Committee to evaluate opportunities to help individuals who are dependent on chronic opioid therapy**

[9] Baron, Michael J., and Paul W. McDonald. Significant pain reduction in chronic pain patients after detoxification from high-dose opioids. *J Opioid Manag* 2.5 (2006): 277-82. Accessible at: https://rsds.org/wp-content/uploads/2015/02/Baron_McDonald.pdf.
[10] Mao, Jianren, ed. (Oct. 26, 2009). *Opioid-induced hyperalgesia*. CRC Press.
[11] Youssef, F., A. Pater, and M. Shehata. Opioid-induced hyperalgesia. *J Pain Relief*, 4.3 (2015): 183.
[12] Supra note 14, pages 174-180.
[13] Scarfo, Keith A. Opioid-Induced Hyperalgesia Syndrome in the Rehabilitation Patient. *Comprehensive Pain Management in the Rehabilitation Patient*. Springer, Cham, 2017. 419-423.

for pain to undergo detoxification and assessment for successful pain management with non-opioid alternatives and relapse prevention counseling and medication. As part of this, we encourage the Committee to ensure that payment policies are designed in a manner that appropriately incentivizes provision of such services, where medically appropriate.

Fourth, there are only three types of medications approved by the FDA for the treatment of OUD: methadone, buprenorphine and naltrexone. The Comprehensive Addiction and Recovery Act (CARA) – particularly Section 303 of that bill – requires that practitioners who are waivered to treat patients with buprenorphine have the capacity to provide, either directly or by referral, *all* FDA-approved medications including methadone and extended-release injectable naltrexone. Currently, the vast majority of patients with OUD, if treated with a medication, will be treated with methadone or buprenorphine – medications that themselves are both opioids. Section 303 of CARA is especially relevant to the work of the Committee because it addresses qualified providers' consideration of *non-opioid* medications for patients with OUD. With FDA's approval of extended-release naltrexone, (a non-opioid alternative) there is an opportunity for patients to be detoxified and treated for opioid addictions with counseling and a non-opioid medicine, when clinically appropriate. Unfortunately, CARA's provisions have not had their full intended effect since there are still coverage and reimbursement barriers associated with all three FDA-approved OUD medications. **We strongly encourage the Committee to consider policies that will remove coverage, reimbursement and other barriers to accessing these vital medications. For instance, several states, such as Massachusetts and New York, have removed prior authorization requirements for all FDA-approved OUD medications. We encourage the Committee to consider mechanisms for removing prior authorization requirements for all FDA-approved OUD and SUD medications on a nation-wide basis in order to expand access to such therapies.**

Fifth, we ask the Committee to consider the needs of individuals with access to care under Medicaid who enter prison or jails with an OUD or other SUD. In some jurisdictions, Medicaid is cut off completely and an inmate, upon release, must re-apply for these benefits. Oftentimes, a person with an addiction will go through detoxification during their incarceration. Therefore, timely access to treatment after release is pivotal to maintaining a road to recovery because the risks for relapse are more severe for this population than other patients with OUD or other SUD.[14] Therefore, we ask the Committee to require Medicaid services to only be *suspended* upon a person's entrance into jail or prison. That way, when released, access to services can be quickly reinstated. Some states have implemented this type of policy in their corrections systems.[15]

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[14] Binswanger, I.A. et al. (Jan. 11, 2007). Release from Prison - A High Risk of Death for Former Inmates. *N Engl J Med* 2007; 356:157-165. DOI: 10.1056/NEJMsa064115. Accessible at: http://www.nejm.org/doi/full/10.1056/NEJMsa064115.

[15] Hagan, E. (July 2016). *Medicaid Suspension Policies for Incarcerated People: 50-State Map*. FamiliesUSA.org. Accessible at: http://familiesusa.org/product/medicaid-suspension-policies-incarcerated-people-50-state-map.

Finally, we are aware, from our conversations with practitioners and families, that certain providers engage in practices that target the vulnerabilities of families and people suffering from OUD and other SUDs – for instance, by charging for services and therapies that are not medically necessary. While some of these practices are best addressed by law enforcement, there are areas in which the Committee may be able to improve the quality of care for Medicare and Medicaid beneficiaries. Specifically, we encourage the Committee to meet with experts in substance use testing, and generally to consider how to detect and prevent frivolous drug tests[16] as well as poor quality[17] and unethical treatment[18,19] for OUD within the Medicaid program.

4. ***How can Medicare and Medicaid better prevent, identify and education health professionals who have high prescribing patterns of opioids?***

Comment –The Committee should consider engaging with the CDC to identify conditions for which high prescribing patterns of opioids are clinically appropriate and indicated (e.g., end-of-life palliative care; physical trauma; and post-surgical care). Such conditions should not be subjected to onerous restrictions that compromise care, including the provision of opioids. However, for all other conditions in which there is chronic opioid prescribing, CMS should require weekly reauthorizations for all other diagnoses if an opioid medication prescription is being written. In the case of patients requiring more than one-month of opioid therapy who do not have clinical conditions for which high prescribing patterns of opioids are clinically appropriate and indicated, we urge the Committee to consider requiring a referral for an evaluation by a board certified addiction specialist. For patients who have been on opioid therapy for a sustained period of time (perhaps defined as at least several months of opioid pharmacotherapy), referral to a board certified opioid addiction specialist should be required to ensure proper care is being provided.

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[16] Schulte, F. and Lucas, E. (Nov. 6, 2017). How Doctors Are Getting Rich on Urine Tests for Opioid Patients. *Bloomberg News*. Accessible at: https://www.bloomberg.com/news/features/2017-11-06/how-doctors-are-getting-rich-on-urine-tests-for-opioid-patients.

[17] Gordon, A. et al., Patterns and Quality of Buprenorphine Opioid Agonist Treatment in a Large Medicaid Program, *J. of Addiction Med*. (2015): 470-477. Accessible at: http://journals.lww.com/journaladdictionmedicine/Abstract/2015/12000/Patterns_and_Quality_of_Buprenorphine_Opioid.9.aspx.

[18] Seville, L.R. et al. (June 25, 2017). Florida's Billion-Dollar Drug Treatment Industry Is Plagued by Overdoses, Fraud. *NBC News*. Accessible at: https://www.nbcnews.com/feature/megyn-kelly/florida-s-billion-dollar-drug-treatment-industry-plagued-overdoses-fraud-n773376.

[19] New York State Office of Alcoholism and Substance Abuse Services. (Feb. 8, 2018). *The New York State Office of Alcoholism and Substance Abuse Services Announces Latest Efforts to Prevent Treatment Fraud and Illegal Patient Brokering: New Public Service Announcements Highlighting New York State's 900+ Treatment Programs* [Press release]. Accessible at: https://oasas.ny.gov/pio/press/20180208TreatmentFraudPSAs.cfm.

5. ***What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?***

Comment – Prescription Drug Monitoring Programs (PDMPs) can reduce the incidence of inappropriate co-prescribing of opioid medications, as well as the co-prescribing of other controlled substances that may have adverse interactions with one another. The Committee should consider policies that will direct Medicare and Medicaid programs to institute new methods for reviewing patients' prescription drug data to identify those being treated with risky combinations of opioids and controlled substances such as benzodiazepines and other sedation-producing drugs. Such methods and data queries could help determine patterns of unsafe prescribing, which, in turn, could trigger additional audits of the prescriber and interventions, as appropriate. Such interventions could include, but not be limited to, issuing notices to the prescriber about safer prescribing practices; requiring re-authorizations (and potential denials) of prescriber prescriptions; requiring a second opinion by a board-certified addiction specialist; or denying payment for the opioid medications. As a recent Senate Homeland Security Committee hearing[20] and report[21] have found, there is ample reason to be concerned about Medicaid funds being expended for inappropriate opioid-related prescribing, and consequently, further investigation and action should be pursued in this arena.

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

Comment – For individuals with OUD, detoxification off of opioids is the first step to establishing an opioid-free recovery. Detoxification must typically take place in a residential facility, hospital, correctional settings, or other controlled environments. Unfortunately, there is a severe lack of access to detoxification in controlled settings, and there are relatively few addiction specialists who are capable of assisting patients in completing outpatient detoxification. Consequently, we urge the Committee to consider manners in which CMS can leverage its existing authority with respect to the Medicaid program, such as through Section 1115 waivers, in order to allow for greater Medicaid beneficiary access to residential detoxification, clinical stabilization, and rehabilitation services. Moreover, we urge the Committee to consider how to make reimbursement available for services in these settings, without requiring a waiver (whether through legislative amendments to the Medicaid statute or otherwise). However, for recovery to be successful, detoxification should be followed by relapse prevention counseling and, when clinically appropriate, medications that have been

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[20] U.S. Senate Committee on Homeland Security & Governmental Affairs. (Jan. 17, 2018). *Unintended Consequences: Medicaid and the Opioid Epidemic* [Hearing]. 115th Congress. 2nd sess. Recording accessible at: https://www.hsgac.senate.gov/hearings/unintended-consequences-medicaid-and-the-opioid-epidemic.

[21] U.S. Senate Committee on Homeland Security & Governmental Affairs. (Jan. 17, 2018). *Drugs for Dollars: How Medicaid Helps Fuel the Opioid Epidemic, a Majority Staff Report of the Committee on Homeland Security and Governmental Affairs, United States Senate*. Accessible at: https://www.hsdl.org/?abstract&did=807403.

specifically approved by the FDA for the prevention of relapse. Therefore, we also encourage the Committee to explore methods of increasing Medicaid beneficiaries' access to these services. Detoxification without relapse prevention increases the risk for overdose.

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

Comment – Among women who have opioid use disorders, the risks of overdose, suicide and serious post-partum behavioral disorders, including relapse to opioid use disorder, are well-documented and significant. Given the extraordinary consequences such events can have on the mother and newborn child, such women should be provided with ready access to gradual, medically managed detoxification, as well as gender-specific counseling services and recovery supports. While, historically, medical professionals have promoted opioid maintenance therapy for pregnant women who have OUD, studies have demonstrated that many women do not want to subject their babies to opioid use and detoxification[22] and, instead, welcome the opportunity to complete opioid detoxification during their pregnancy. Given that detoxification during pregnancy is available, but not a common practice,[23] and such treatment can nearly eliminate the risk for neonatal abstinence syndrome and neonatal withdrawal (and the costly neonatal intensive care that it requires), obstetricians should be provided with training and incentives to offer their patients appropriate education about detoxification as a treatment alternative to agonist therapy. This is consistent with the provisions within CARA Section 303 related to provider training.

Thank you for the opportunity to comment and your consideration of these recommendations. We welcome the chance to meet with you and your staff to discuss as you begin developing legislation.

Sincerely,

Peter Norman
Senior Vice President, Policy & Government Relations

Enclosure

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[22] Howard, Heather. Experiences of opioid-dependent women in their prenatal and postpartum care: Implications for social workers in health care. *Social work in health care* 55.1 (2016): 61-85.
[23] Bell, J. et al. (Sept. 2016). Detoxification from opiate drugs during pregnancy. *Am. J. Obstet. Gynecol.* 215(3):374.e1-6. DOI: 10.1016/j.ajog.2016.03.015. Accessible online: https://www.ncbi.nlm.nih.gov/pubmed/26996987.

Monday, April 24, 2017

The Honorable Mark Dayton
Governor of Minnesota
130 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd
St. Paul, MN 55155

The Honorable Michelle Benson
Chair, Senate Health and Human Services Finance and Policy Committee
Minnesota State Senate
3109 Minnesota Senate Building
95 University Ave W
St. Paul, MN 55155

The Honorable Matt Dean
Chair, House Health and Human Services Finance Committee
Minnesota House of Representatives
401 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd
St. Paul, MN 55155

Re: Reverting to HF770 Language in HF945

Dear Governor Dayton, Chairwoman Benson and Chairman Dean,

On behalf of the American Society of Addiction Medicine (ASAM), the nation's oldest and largest medical specialty organization representing more than 4,300 physicians and other clinicians who specialize in the treatment of addiction, and the Minnesota Society of Addiction Medicine (MNSAM), we would like to take this opportunity to provide our support for the legislative language in Rep. Dave Baker's HF770. With the opioid addiction and overdose epidemic significantly impacting the country and Minnesota, MNSAM and ASAM appreciate the effort to ensure patients in Minnesota are receiving high-quality, evidence-based and comprehensive addiction treatment.

MNSAM and ASAM are dedicated to increasing access to and improving the quality of addiction treatment for patients in Minnesota and across the country. To that end, we are committed to advocating for a state addiction treatment system that provides access to all Food and Drug Administration (FDA)-approved medications to treat opioid addiction. HF770 removes the Medicaid "buy and bill" requirement to allow providers to bill practitioner-administered medications for substance use disorders and addiction as a

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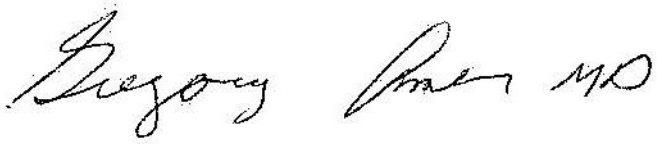
pharmacy benefit and initiates a long-term policy option to help address the current opioid epidemic. The current Minnesota statute places the "buy and bill" requirement on provider-administered MAT for opioid addiction, which is specific to the FDA-approved opioid antagonist naltrexone. Removing this Medicaid requirement will ensure access to all FDA-approved medications for patients in Minnesota, so they can receive the right care they need when they need it.

We understand that the original language included in HF770 removing the Medicaid "buy and bill" requirement was recently dropped by the House Health and Human Services omnibus bill, HF945, in favor of offering a one-time grant program. This grant program is meant to assist providers in purchasing the first dose of a non-narcotic injectable or implantable medication to treat substance use disorders and addiction. While well-intentioned, this grant does not address the ongoing long-term issues which restrict medication access for Medicaid-insured patients who have this chronic disease. As the omnibus legislation advances to conference committee, MNSAM and ASAM ask the committee to revert to the original language of HF770, which removes the Medicaid "buy and bill" requirement.

MNSAM and ASAM share the state of Minnesota's goal of providing quality and evidence-based comprehensive addiction treatment services. We thank you for considering the original language of HF770 to be included in HF945 and offer our support for the passage of the omnibus bill with that specific language. Please do not hesitate to contact Brad Bachman, Manager of State Government Relations, at (301) 547-4107 or bbachman@asam.org, if MNSAM and ASAM can be of service to you. We look forward to working with you.

Sincerely,

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



Gregory M. Amer, MD, FASAM
President, Minnesota Society of Addiction Medicine

CC:
The Honorable Jim Abeler
The Honorable Tony Lourey
The Honorable Karin Housley
The Honorable Paul Utke
The Honorable Joe Schomacker
The Honorable Tony Albright
The Honorable Jennifer Schultz
The Honorable Debra Kiel

The Honorable Mark Koran
The Honorable Dave Baker