February 16, 2018

The Honorable Orrin Hatch, Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden, Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of NAADAC, the Association for Addiction Professionals, I appreciate the opportunity to respond to your request for feedback on the opioid epidemic. NAADAC the Association for Addiction Professionals, represents the professional interests of more than 100,000 addiction counselors, educators and other addiction-focused health care professionals in the United States, Canada and abroad. NAADAC's members are addiction counselors, educators and other addiction-focused health care professionals, who specialize in addiction prevention, treatment, recovery support and education. An important part of the healthcare continuum, NAADAC members and its 47 state and international affiliates work to create healthier individuals, families and communities through prevention, intervention, quality treatment and recovery support. Founded in 1972, as the National Association of Alcoholism Counselors and Trainers (NAACT), the organization's primary objective was to develop a field of professional counselors with professional qualifications and backgrounds. The organization evolved and became the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) in 1982, uniting professionals who worked for positive outcomes in alcohol and drug services. NAADAC's new name - NAADAC, the Association for Addiction Professionals - was adopted in 2001 and reflects the increasing variety of addiction services professionals: counselors, administrators, social workers and others, who are active in counseling, prevention, intervention, treatment, education and research. NAADAC strongly urges you to consider the information and recommendations that we offer in this letter to build a national strategy to combat the opioid crisis as well as to affect the larger crisis of alcohol abuse and addiction and other drugs that are affecting the well-being of individuals, families and communities across America.

NAADAC recommends and urges the following recommendations to strengthen the access to, treatment and recovery of, those persons abusing and addicted to prescription opioids and their family members as well as the specifically trained and educated professionals who treat them.

To address your specific questions, please find the following:

1) How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimized the risk of developing OUD or other SUDs?

Create Medicaid and Medicare coverage for alternative evidence-based therapies like Cognitive Behavioral Therapy (CBT), biofeedback, mindfulness, Acceptance Commitment Therapy (ACT), massage, chiropractic care, acupuncture, electromagnetic brain stimulation and hypnosis.

Provide tax breaks, higher reimbursement rates, and/or cash incentives for medical doctors who promote evidence based alternative therapies.

Provide new studies or past literature highlighting the efficacy of alternative pain management therapies to medical doctors who take Medicaid or Medicare for pain management clients.

2A) What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid?

Medical doctors that receive kick-backs for prescribing opioid-based medications are a barrier to eliminate that behavior. These arrangements which often are consulting, speaking, or advising roles for pharmaceutical companies are problematic and create a conflict of interest. The lobbying by big pharma who supports both political parties with substantial amounts of money is another barrier to politicians making choices that are healthier for Americans. We recommend capping or limiting or even eliminating the amount of kickback money that medical doctors can receive from a pharmaceutical company related to opiate medication prescriptions.

Not enough Random Controlled Trials (RTCs) and other quantitative or qualitative studies on the efficacy of non-pharmaceutical therapies. These types of studies are time intensive, expensive, and labor intensive and need to be funded by the Congress. Conversely big pharma has massive amounts of funds for research and developing RTCs for new medications that may have unintended consequences, such as opioids and medical marijuana.

Continue research on medical marijuana, synthetic marijuana, and other non-opioid based medications as alternative medications for treating chronic pain issues. However, the current prolific use of medical marijuana without the research and FDA approval system that usually is followed for a “medication” has been curtailed with medical marijuana, making it the only medication that has not gone through that process in modern times. NAADAC has concerns that we will see the next drug tsunami to be related to marijuana use.

Non-pharmaceutical therapies are expensive and time-consuming verses taking a pill. Therapies like CBT, massage, chiropractic, biofeedback, etc. are expensive and time consuming and may take significant work and commitment from the patient. Future technology and innovation could help with this. Funding should focus on new technologies to address pain that are less time consuming and take little effort to eliminate potential barriers.

The US public and American culture wants a quick and easy intervention, taking a pill is quick and easy and takes no work. As mentioned before this is a significant barrier to overcome. Teaching impulsive control and alternative ways to reduce stress and increase bonding should start in pre-school and be a part of the school curriculum and environment through college.

2B) How can those barriers be addressed to increase the utilization of those non-pharmaceutical therapies when clinically appropriate?

Policy and laws that eliminate kickbacks (consulting, speaking, or advising roles) for physicians who prescribe specific schedule drugs (opioids). This would eliminate MD's incentive to prescribe opiates.

Policy and laws that allow prescribing opiates for only short term acute pain. The research is clear that long term prescribing practices are ineffective and ultimately has the potential to trigger a Substance Use Disorder in patients. There is no evidence to maintain a person on opiates for a sustained period of time.

Educational campaigns for MDs on the consequences of prescribing opiates long term and also emphasizing the clinical efficacy of non-pharmaceutical approaches along with counseling specific to recovery should be enhanced. Prescribers working with addiction counselors would create a more informed approach to treatment and recovery. Creating "community safety nets" of addiction treatment teams to consult on patients that are not adhering to medication standards before the patient moves into full-blown addiction would reduce those addicted and create interventions to alternative means of support. Addiction counselors teaching SBIRT to nurses, physicians, psychiatrists and other social workers would be helpful in this process. Setting protocols for patients to be immediately seen, or seen at the hospital by an addiction counselor specialist before release, would be helpful in the transition from hospital care to community care.

Additional research funding or tax breaks to companies who are creating new state of the art empirically based approaches to deal with pain management, which are quick and easy like websites, apps, and other manualized therapies.

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 other SUDs to improve patient outcomes?

Legislatures could create a pay scale for reimbursement that favors this practice, which includes a documentation system in order to receive reimbursement.

Legislatures need to create standards for practice for those who receive Medicaid business to provide adequate addiction specific services. The issue is that unless a professional is trained in addictive disorders, they are not effective in treating the patient who is moving in their progression from use, abuse to dependency. Parity for payment for addiction services also needs to be considered in order to create incentives for addiction professionals to continue to

perform the work they are doing. Poor pay, lack of benefits for the workforce is an enormous issue.

Congress can continue to fund opioid and other drug programs, however, without an educated and trained workforce, this current crisis and the crisis yet to come, will remain untouched. A national strategy to build and retain the addiction-specific workforce is badly needed. Addiction and substance use disorders along with co-occurring mental health disorders has created a more complex set of issues to address that require a better educated, trained, and supervised staff. A full continuum of care, from prevention to intervention, treatment and ongoing recovery support is necessary to turn this tide. Creating loan forgiveness programs, programs for tuition support such as the Minority Fellowship Program for Addiction Counselors need to be expanded and created at the Bachelor's level.

We need not only large providers of care; we also need smaller providers of care as not all patients seek assistance through large systems. Many patients do not want to seek assistance in a mental health center. This variety of providers help to create the "safety net" I referred to earlier.

Every patient should be assessed for level of substance use disorders, and then a corresponding treatment plan developed with the patient and their consulting team, that should include an addiction specialist and a recovery support specialist.

Clear information on Medicaid codes and processes for billing is essential for treatment and also to maintain a workforce. NAADAC learns of complaints from providers that their state does not give clear codes, changes the codes without notice and then comes back to the treatment program to collect fees for incorrect billings. We need a transparent system that is well managed in each state. An addiction specialist should be on each Insurance Commission and/or Medicaid Committee/Board in order to support the needs of the patients they serve and receive and communicate the standards and requirements from the state Medicaid office. Trainings should be conducted that include solution-focused problem solving of payment to treatment and treatment reimbursement.

Incentivize education and professional development at all layers of care from prescribers to addiction counselors around the strategies available to address pain.

4) Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?

Legislation could enact policies and applicable laws to require medical providers to utilize the PDMP system to look for individuals who are Doctor shopping. Federal Law could require all states to adopt the PDMP system and enforce penalties for prescribers who do not comply.

Pharmacy programs to collect medications unused are a helpful community activity.

5) How can Medicare and Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

The federal government could use the PDMP program to monitor physician prescribing practices and create a monitoring agency and a disciplinary process for those who violate prescribing policies. Assessments of prescribers to assess if they have their own substance use disorder may be essential in preventing further abuse. Cross education panels of persons in recovery from opioid addiction may be helpful for the prescriber to learn and change their own thinking regarding the course of addiction and how common and quick a person becomes dependent on the prescriptions they are prescribing.

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

Interview companies who have created state of the art databases that could be utilize the PDMP programs to provide real time data to the Federal agencies including Medicare and Medicaid and health care professionals. Create a small oversight agency that can monitor and intervene when appropriate prescribing practices are violated.

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

First, identifying what those best-practices are and what are the root practices that are transferrable to other services would be helpful.

Talking with addiction treatment providers to learn what their experience is “on the street” and taking those lessons to filter out the practices that are working. Providing a consulting prescriber at publically funded addiction treatment agencies (as they do not have the funds to support this type of effort) to assist in the identification of what patients/clients need for specific types of medications, including opioid treatment medications, to support their medical issues, treatment and recovery.

Create codes for prescribers when they refer and create codes for alternative medicine and complementary medicine options.

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

Parenting education regarding the genetic and environmental antecedents that create a higher risk for use, abuse and dependence and the other risk factors that trigger use and the protective factors that support the nurturing and development of children from birth to early adulthood.

Designing school substance use disorder specialist programs in schools from pre-school to college that identify and support children affected by families of OUD/SUD. Creating “natural helpers” in schools of classmates and adults, from janitor to administrator, that are there to listen, support and refer students that are experience adverse experiences.

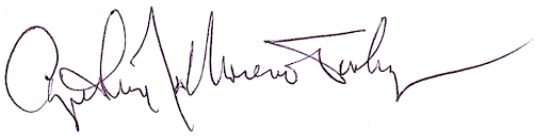
Supporting (not penalizing) women, men and children in the child welfare system with education and tools to communicate with their children, reduce their own levels of stress and develop methods for opportunities to move out of the child welfare system and poverty.

I will add a piece of my personal story here as it is relevant to this letter. My mother was addicted to street and prescription medications, and due to her early onset addiction, she left the family when I was 8 months old. Following her departure, my sibling and I became wards of the courts. During the next 18 years, it was very rocky, with delinquency, school behavior difficulties and learning difficulties. Had it not been for a positive foster home experience in my Junior and Senior year, I would not have retained the recovery began at 15, nor stayed out of the criminal justice system, nor completed college and become an addiction specialist and social worker that now works to educate the legislature, the public and train addiction specialists to perform their work more effectively. There are methods that can transform the opioid crisis we are in now; they take consistency, time and a dedication to do so.

NAADAC stands ready to assist in technical assistance and consulting to support the health of those persons affected by the diseases of OUD/SUD and their families.

Thank you again for this opportunity to comment, we are grateful you had the foresight to reach out. My contact information is cynthia@naadac.org or 703.741.7686 Ext 119.

Sincerely,



Cynthia Moreno Tuohy, BSW, NCACII, CDCIII, SAP
NAADAC, Executive Director

- Brie Riemann's Perspective (Assistant VP of the National Counsel of Behavioral Health) for her insight and support is some of the wording of this document.