ADVOCATES | FOR OPIOID ADDICTION TREATMENT

March 6, 2023

Health, Education, Labor & Pensions Committee
United States Senate
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Member:

Advocates for Opioid Addiction Treatment (AOAT) is comprised of more than 700 opioid treatment program (OTP) facilities and office-based opioid treatment (OBOT) providers in 46 states. Our health care teams provide lifesaving medication-assisted treatment (MAT) to roughly 215,000 patients every day. We employ physicians, pharmacists, nurses, counselors, administrators, and clerical staff to form interdisciplinary treatment teams that provide comprehensive, evidence-based care to patients suffering from opioid use disorder (OUD). Our patients are disproportionately low-income and rely on adequate public insurance coverage to ensure they have access to services that allow them to reduce or eliminate drug use and be productive members of society.

This week, you may be meeting with a group who is seeking to advance the so-called *Modernizing Opioid Treatment Access Act* (S. 644/H.R. 1359). This legislation would allow physicians to write methadone prescriptions for patients with OUD to pick up at pharmacies. Methadone is a very effective component of treatment, when coupled with other services and supervision. However, Methadone is also a Schedule II narcotic that can result in overdose and death if it is misused. One need not look any further than SAMHSA's and other federal agency reports from the 2000s which showed that physician prescribing of methadone in the office setting led to increased overdose deaths.[1,2,3,4] Experience in other countries have shown the same result, along with a higher likelihood of patients prematurely leaving treatment.[5,6]

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[1]Center for Substance Abuse Treatment. Methadone-Associated Mortality: Report of a National Assessment. 2003. SAMHSA Publication No. 04-3904. https://atforum.com/documents/CSAT-MAM_Final_rept.pdf
[2]US Department of Justice, National Drug Intelligence Center. Methadone Diversion, Abuse, and Misuse: Deaths Increasing at Alarming Rate. 2007. Product No. 2007-Q0317-001. https://www.justice.gov/archive/ndic/pubs25/25930/index.htm
[3]U.S. Government Accountability Office. Methadone Associated Overdose Deaths: Factors Contributing to Increased Deaths and Efforts to Prevent Them. 2009. GAO 09-341. https://www.gao.gov/assets/gao-09-341.pdf
[4]Center for Substance Abuse Treatment. Methadone Mortality – A Reassessment. 2010. https://cdn.voxcdn.com/uploads/chorus_asset/file/19541909/Methadone_Mortality_A_2010_Reassessment.0.pdf
[5]John Strang, Wayne Hall, Matt Hickman, Sheila M Bird. Impact of supervision of methadone consumption on deaths related to methadone overdose (1993-2008). BMJ 2010;341:c4851. DOI:10.1136/bmj.c4851.
[6]Graham Gauthier, Joseph K. Eibl and David C. Marsh. Improved treatment-retention for patients receiving methadone dosing within the clinic providing physician and other health services (onsite) versus dosing at community (offsite) pharmacies. Drug and Alcohol Dependence. 2018;Volume 191:pages 1-5. DOI:10.1016/j.drugalcdep.2018.04.029.

Proponents of this dangerous policy point to a couple of limited studies purporting reduced methadone-related overdose deaths resulting from COVID-era take home flexibilities while ignoring the robust resources dedicated to patient assessment, observation and diversion control employed in OTPs. MAT with methadone in the OTP setting is safe because OTPs are heavily regulated, required to employ stringent anti-diversion programs, maintain comprehensive inventory tracking management systems, and see patients on a regular, often daily basis, where observation and assessments can take place in person, particularly during the first few months of treatment and OTPs have strong outreach capabilities to assist patients with their take-home medications. The vast majority of OBOT providers – including our own - and pharmacies are ill-equipped to adopt these patient and public safety measures.

Federal data show that buprenorphine is one of the most diverted drugs in the country.[7] It is not hard to see the same happening with methadone if the doctors currently prescribing buprenorphine were allowed to prescribe methadone, only, in this case, with lethal consequences. In addition, significant increases in overdoses and deaths would increase the stigma around methadone like it did in the 2000s, resulting in patients avoiding seeking effective MAT with methadone when it could save their lives. It would also harm the evidence-base we have worked so hard to build to de-stigmatize methadone and could result in insurance utilization restrictions such as fail-first on methadone-only or decreased reimbursement rates for real medication assisted treatment.

Reducing MAT to just prescribing medication ignores the reality that behavioral health and supports are critical components of recovery. Simply writing a 30-, 60-, or 90-day prescription to an OUD patient and not seeing the patient or monitoring the patient until the next prescription refill does not constitute treatment. Medication merely stabilizes the patient so that the treatment, namely the behavioral health services, can begin. Simply stated, MAT is a program, geared towards long-term positive outcomes, not just a pill, which only puts a proverbial band aid on an incredibly complex disease.

While we agree that many regulatory changes need to happen quickly in order to slow-down the wave of overdose deaths plaguing our country, the groups promoting physician prescribing and pharmacy delivery of methadone are taking advantage of regulators' desperation to find quick solutions to overdose deaths by removing some of the logical safeguards that OTPs have provided, inciting policymakers to believe that methadone is not otherwise easily accessible. In fact, over 87% of US citizens can currently access an existing OTP within 30 miles or a 40-minute drive (which are Exchange marketplace network adequacy standards). Moreover, with the implementation of the extended medication take home rules passed just this past December by Congress, and the even more flexible proposal for increased access to OTPs by SAMHSA (who recognized that take homes as managed by OTP physicians and their multidisciplinary teams during the COVID pandemic were determined to be highly safe), methadone combined with multidisciplinary treatment is more accessible through OTP's than it has ever been. Some of us remember 25+ years ago the public outcry on how can methadone treatment allow patients to just get medicine and not receive much needed psychosocial treatments - do we really want to "modernize" by going back to those days? It makes sense that medicine can diminish the physical pain of withdrawal and reduce the craving for opioids that opioid-dependent individuals

[7] The National Survey on Drug Use and Health: 2021, SAMHSA

have but medication alone cannot change dysfunctional patterns of thinking and behavior amassed over a lifetime and/or many years of addictive behavior as counseling and therapy can.

We strongly support expanding access to MAT, not just medication. That is why AOAT has developed an evidenced-based policy proposal to evaluate the safety and efficacy of OTP physicians collaborating with health care professionals outside of the OTP setting dispensing methadone. We will be following up with you shortly to request a meeting to present our policy proposal.

Sincerely,

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