

June 30, 2022

The Honorable Patty Murray
Chair
Senate Committee on Health,
Education, Labor, and Pensions
154 Russell Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
Senate Committee on Health, Education,
Labor and Pensions
217 Russell Senate Office Building
Washington, DC 20510

Dear Chair Murray and Ranking Member Burr:

On behalf of the American Academy of Addiction Psychiatry (AAAP), I thank you for the work underway to address the devastating impact of the mental health and substance use disorder crises on individuals, families, and communities nationwide. AAAP is a professional organization representing specialists in Addiction Psychiatry and other healthcare professionals who treat patients with substance use disorders (SUDs). AAAP's main educational mission is to educate healthcare professionals in the prevention and treatment of SUDs and co-occurring psychiatric disorders; we are an interprofessional Continuing Medical Education (CME) provider. AAAP is focused on working with the Administration, Congress, and experts in the field of addiction treatment to develop and implement science-based policies and programs to accomplish our shared goal of ending the opioid epidemic, addressing co-occurring mental health problems, and providing effective treatment for our patients.

Medications for opioid use disorder (MOUD) involve a combination of FDA-approved medications (methadone, buprenorphine, and naltrexone) that target the brain and psychosocial interventions (counseling, skills development) aimed at improving treatment outcomes. Many patients need psychosocial counseling and support services to achieve clinical stability, and prescribers must be able to refer or provide appropriate adjunctive counseling and support services, specifically for buprenorphine. Integrating SUD services, as well as screening for early risk factors for SUDs, into mainstream healthcare and ensuring all Americans have access to these services has the power to substantially improve outcomes for individuals and reverse the opioid crisis. Addiction psychiatrists play a critical role in diagnosing and treating SUD and the other psychiatric disorders that typically accompany it. Addiction psychiatry bridges the gap between SUD and the other psychiatric disorders that lead to SUD. The treatment of addiction using psychiatrists results in better psychological as well as physical health, a lower prevalence of substance use, and improved social lives.

As the Senate Health, Education, Labor and Pensions Committee crafts comprehensive legislation on mental health and substance use disorders, we would like to offer the following recommendations for addressing the current treatment gap and increasing the number of clinicians who work at the intersection of treating substance use disorders and mental health conditions.

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Improving the Workforce

A continuum should be considered to incentivize medical residents into fellowships for addiction psychiatry, the only fellowship focused on treating co-occurring substance use and psychiatric disorders. Currently, slots are not being filled for addiction psychiatry given the medical loans burdening residents coupled with the low reimbursement rate for addiction psychiatry. Studies show that primary care reimbursement for the same service were 23.8% higher than for behavioral health office visits.¹ Medical students opt to join the workforce rather than complete a fellowship due to the financial burden. To build the workforce in this critical area of addiction and co-occurring mental health expertise, we strongly urge you to prioritize addressing the workforce shortage.

Specifically, we urge continued support for programs such as the Mental Health and Substance Use Disorder Workforce Training Demonstration Program which awards grants to institutions to support training for medical residents and fellows in psychiatry and addiction medicine who are willing to provide substance use disorder treatment in underserved communities. Likewise, the National Health Service Corps (NHSC) Loan Repayment Program for Substance Use Disorder Treatment Workforce programs provides loan repayment for mental health professionals working in high-need communities or federally designated mental health professional shortage areas. We also support recruitment, enrollment, and retention of students from disadvantaged backgrounds and shortage areas. In addition, we offer the following workforce recommendations:

- Encourage the Committee to consider alternative avenues of financial support such as scholarships and stipends for qualified students who pursue behavioral health professions and serve in underserved communities to strengthen the size, distribution, and diversity of the behavioral health workforce.
- Ensure addiction psychiatrists are eligible for all workforce programs and create a specific three-year loan repayment program for addiction psychiatry to help address the vacancies in fellowship slots.
- Create pipeline programs in high schools and universities with information, education, and opportunities to gain insight about working in psychiatry, including addiction psychiatry and other subspecialties with a focus on partnering with schools serving marginalized and underserved communities.
- Work with the Finance Committee to increase Medicare and Medicaid reimbursement for behavioral health. Low reimbursement for health professionals and facilities of all types is an important factor that discourages physicians in training, and other future healthcare professionals, from pursuing careers in behavioral health. It is encouraging that the Department of Labor has made reimbursement its top parity enforcement priority, but while badly needed, that will only affect the private insurance market. Attention should be made to improving behavioral health provider and facility reimbursement within Medicare and Medicaid, which are also notoriously poor reimbursors compared to other healthcare professionals and facilities. In

¹ Melek, S.P., et al. (November 2019) Addiction and mental health vs physical health: Widening disparities in network use and provider reimbursement. *Milliman Research Report*. <https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx>

fact, this often fuels the low reimbursement in commercial insurance because commercial insurers base many of their reimbursement strategies on Medicare rates.

Improving Education and Training for Clinicians

We also strongly encourage ongoing support for education and training of the current workforce in treating substance use disorders and co-occurring mental health conditions. Newly released data from the Centers for Disease Control and Prevention (CDC) estimates that nearly 108,000 Americans died from drug overdoses from January to December 2021, the highest number of annual overdose deaths ever recorded in the U.S. In response to this national epidemic, the White House's Office of National Drug Control Policy (ONDCP) has proposed a comprehensive plan, which includes expansion of access to treatment and providing science-based training for healthcare providers administering medication to individuals with opioid use disorder (OUD).

The Providers Clinical Support System (PCSS), supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), plays a critical role in expanding the number of clinicians (including physician assistants and advanced practice registered nurses) using medication for opioid use disorders (MOUD), increasing understanding of the importance of FDA-approved medications, and ultimately increasing access to effective treatment. ***In two years, over 111,000 clinicians were trained through the program, as well as an additional 15,000 medical students. As of January 2022, PCSS trainings increased over 400 percent over 5 years due to the demand.*** It also has resulted in unprecedented collaboration of multidisciplinary healthcare practitioners from primary care to nurses, physician assistants and social workers, to better meet the needs of people with SUDs. Although the current initiative has provided multiple trainings and mentoring support, a significant need remains to increase the number of healthcare providers to address the nation's lack of adequate access to care and treatment for opioid use disorder and other SUDs.

Physicians and other health professionals play an important role in educating their patients and colleagues about substance use and SUDs: screening, diagnosing and treating patients, and modeling positive attitudes to reduce the stigma attached to SUDs. A lack of preparedness has been identified as a barrier in the provision of buprenorphine (one of three FDA-approved OUD treatments) to patients with OUD by early career family physicians, and lack of appropriate education has shown to foster negative attitudes toward provision of MOUD. Comprehensive and science-based training on SUDs and treatment and recovery modalities have the potential to overcome these deficits. Through the PCSS program, SAMHSA promotes provider education and collaboration through its grants and programs, including the Providers Clinical Support System-Universities (PCSS-U) and PCSS. PCSS-U promotes SUD education in professional schools and aims to educate students in treating OUD upon graduation. The PCSS program expands the number of licensed providers completing training requirements for prescribing MOUD and provides mentoring and other supports for practitioners treating OUD.

To address the ongoing need to provide adequate training for all healthcare practitioners to expand access to MOUD, AAAP recommends that the Committee:

- **Create a separate permanent authorization for SAMHSA's Providers Clinical Support System (PCSS). SAMHSA initially created the PCSS program from the authorities granted it by the Drug Addiction Treatment Act of 2000, specifically Section 509 of the Public Health Service Act.** The pool of practitioners eligible to prescribe MOUD has expanded from physicians, to nurse practitioners and physician assistants (Comprehensive Addiction and Recovery Act of 2016), and now to clinical nurse specialists, certified registered nurse anesthetists, and certified nurse

midwives (Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities of 2018). To date, some 111,000 healthcare practitioners have been trained by PCSS programs, and 15,339 by PCSS-U programs. With the number of overdose deaths now surpassing 100,000 according to latest CDC figures and with the ongoing fentanyl crisis, the need for training and expanded access to MOUD is increasing even more.

Supporting Integrated Care

We also encourage support for the Collaborative Care Model (CoCM), a proven, measurement-based approach to providing treatment in a primary care office that is evidenced-based and already reimbursed by Medicare, with established CPT codes. CoCM involves a primary care physician working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads. This model allows patients to receive behavioral healthcare, including for substance use disorders, through their primary care doctor in the primary care setting, alleviating the need to seek behavioral health services elsewhere, unless the behavioral health needs are more serious. Unlike other models of integrated behavioral healthcare, CoCM is supported by over 90 randomized control studies which indicate that implementing the model improves access to care by marginalized and underserved populations. CoCM is currently being implemented in many large healthcare systems and practices and is reimbursed by several private insurers and Medicaid programs.

Widespread adoption of the CoCM by primary care practices across the country would best put into action the most highly evidence-backed, measurement-based, and best practice model of integrated primary and behavioral healthcare delivery. It also uses the workforce more efficiently by having a population-based approach. However, one of the most significant impediments to adoption of CoCM is the start-up cost for primary care practices. **As such, AAAP encourages Congress to pass H.R. 5218, The Collaborate in an Orderly and Cohesive Manner (CoCM) Act, which would assist primary care practices in setting up CoCM arrangements by providing grants to implement CoCM and establishing CoCM technical assistance centers to ensure that practices are correctly implementing the model.**

AAAP also supports legislation that includes funding for more research studies into other promising behavioral and primary care integration models. Congress should promote proven, evidence-based models of care that have demonstrated improved patient outcomes. For example, other models like the Primary Care Behavioral Health model, include varied approaches that are not measurement-based or population-based, and as a result, continue to provide one-to-one care that does not address the access issue. An intentional effort to produce evidence to support additional integrated care models would benefit patients, clinicians and health systems. However, to date, no other model has demonstrated improved patient outcomes like the CoCM.

In addition to supporting implementation of the CoCM, identifying ways for clinicians to treat across state lines will help to improve patients' access to care and support continuity of care.

Ryan Haight Act

Lastly, we strongly urge you to ensure the in-person evaluation for prescribing controlled substances under the Ryan Haight Act is permanently lifted after the COVID-19 Public Health Emergency (PHE) ends. During the PHE, the Drug Enforcement Agency has used its authority to waive the in-person requirement prior to prescribing a controlled substance. This has enabled providers to safely prescribe controlled substances remotely using telemedicine, increasing access to clinically appropriate

medications, including for mental health and substance use disorder treatment. The *Journal of Substance Abuse Treatment* published a study on two harm reduction primary care programs providing buprenorphine treatment for opioid use disorder via telehealth. The study found the removal of the in-person requirement greatly increased access to care and addressed health inequities.² This is especially important as mental health and substance use disorders are impacting a growing number of the people across the country.

Thank you for your leadership and dedication to improving services for substance use and mental health disorders. As legislation moves through the process, please use AAAP as a resource. If you have questions, feel free to contact Michelle Dirst at mdirst@aaap.org or (401) 654-6798.

Sincerely,

A handwritten signature in black ink that reads "Larissa Mooney". The signature is written in a cursive, flowing style.

Larissa Mooney, MD
AAAP President

² Wang, L., et al. *Journal of Substance Abuse Treatment*. January 15, 2021.
[https://www.journalofsubstanceabusetreatment.com/article/S0740-5472\(20\)30529-8/fulltext](https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(20)30529-8/fulltext)