American Association for the Treatment of Opioid Dependence, Inc.

The Mainstreaming Addiction Treatment (MAT) Act: Fact-Checking the "Fact" Sheet

OPPOSE S. 445

The facts on the ground have changed.

Since the MAT Act was first introduced, three important changes occurred that require close scrutiny and reconsideration of this proposed policy.

First, in 2019, the vast majority of opioid overdoses were among people who started using prescription opioids but transitioned to heroin when they were precipitously discharged by their prescriber. However, in 2021, approximately 70% of opioid overdose deaths were caused by illicit fentanyl – a much more powerful opioid. Many victims are not aware that the drugs they use contain fentanyl. Most fentanyl in the drug supply today is illegal and comes from either China or Mexico. There is emerging evidence that buprenorphine may be insufficient to effectively treat individuals with Opioid Use Disorder (OUD) using fentanyl.[i] As such, additional resources must be dedicated to engaging people in treatment or we risk increased diversion and failed treatment.

Second, in 2021, SAMHSA exercised its authority to change regulations related to the X-Waiver. As of April 28, 2021, training is no longer required for providers to obtain an X-waiver and prescribe buprenorphine for up to 30 patients. Providers may also forgo certification to counseling and other ancillary services. Given this change, the X-waiver would not appear to serve as a barrier to getting more physicians to prescribe buprenorphine and the MAT Act will only serve to create unregulated treatment programs.

Third, in 2018, Congress passed the SUPPORT Act. In it, Congress sought information about the efficacy of services provided by buprenorphine prescribers, given the billions of dollars and decades of policy efforts to improve access to treatment and decrease overdose deaths. However, HHS has failed to comply with the requirements of the SUPPORT Act thus providing no data that offer real information into what happens in DATA 2000 practices, if they are providing evidence-based treatment services, and whether or not they are helping to reduce overdose deaths. Of most concern is that the policy strategy for the past five years to increase patient caps and eliminate provider training and other requirements is not working as our country continues to have record numbers of overdose deaths.

The MAT Act "Fact" Sheet	✓ FACT CHECK
*"For two decades, **buprenorphine** has been used as a safe, effective and life-saving **medication-assisted treatment (MAT)** for individuals suffering from a substance use disorder."*	It's true that buprenorphine, **in combination with psychosocial services**, has been effectively used for two decades. However, the vast majority of individuals currently receive no counseling. This has led to lower treatment retention and poor clinical outcomes.[ii,iii] **Simply prescribing medication alone is not medication assisted *treatment*.**
*"Medical professionals need a **special DEA waiver** to prescribe buprenorphine to treat substance use disorder, which leads to treatment bottlenecks and a lack of providers."*	No such bottleneck exists. SAMHSA approves applicants within 45 days. **There currently are more than 121,000 waivered prescribers approved to treat more than 7.5 million patients.**[iv] This is more than triple the number of estimated individuals living with an opioid use disorder in our country. However, only about half of the waivered medical practitioners are actually prescribing[v], indicating there are *other* barriers.
*"This outdated waiver requirement has stuck around even though **medical professionals can prescribe the same drug for pain** without jumping through bureaucratic hoops."*	In response to the opioid crisis, federal and state authorities worked urgently to implement prescribing limits and increase prescriber education to mitigate the misguided prescribing practices that contributed to the epidemic. **This legislation moves in the opposite direction by removing the education requirements and limits that currently protect consumers** and making it easier to prescribe a medication known to be highly diverted and misused.

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*"Removing this barrier will **massively expand treatment access**, making it easier for medical professionals to integrate substance use disorder treatment into primary care settings."*	Eliminating the waiver will **massively expand access to *medication*, not *treatment*.** This legislation does not provide medical professionals with the resources needed to integrate quality substance use disorder treatment into their settings. Many individuals with an opioid use disorder engage in polysubstance misuse, much of which **requires psychosocial interventions, not medication alone**. Of adults with a substance use disorder, 37.9% also have a co-occurring mental health disorder.[vi]
*"After nearly **20 years of safe treatment**, there is no good reason to maintain a separate, more burdensome regulatory regime restricting access to safe, proven addiction treatments including buprenorphine."*	**There are no data on the efficacy or quality of MAT provided in primary care settings**. There is, however, data available on the rates of buprenorphine misuse.[vii] The RADARS® (Researched Abuse Diversion Addiction Related) surveillance system found that during 2018, individuals presenting for opioid treatment in the U.S. reported **misuse of buprenorphine** in 27.4% of cases and within these, 15.3% indicated **misuse of buprenorphine by injection** (unpublished data on file).
*"The additional wavier requirement reflects a **longstanding stigma** around substance use treatment and sends a message to the medical community that they lack the knowledge or ability to effectively treat a patient with substance use disorder."*	The stigma surrounding MAT for opioid use disorder is generated in large part when diversion and misuse of these medications occur. Diversion control plans are not required of MAT provided in a primary care setting. **The rate of buprenorphine diversion has been *steadily increasing*** as more buprenorphine is prescribed.[viii] **The number of opioid treatment admissions reporting buprenorphine as a primary drug of MISUSE has also *steadily increased*.** [6]
*"Practitioners are **already required to obtain a license** to prescribe controlled substances and meet any state-level requirements to prescribe buprenorphine."*	The requirement to obtain a license has **already proven insufficient to ensure safe prescribing practices.** A lack of adequate prescriber training on best practice guidelines for pain management and opioid prescribing has been identified as a significant factor in the development of the opioid epidemic. The waiver requirement addresses these past wrongs and **helps protect consumers** from untrained practitioners inappropriately prescribing powerful opioid medications.
*"After **France took similar action** to make buprenorphine available without a specialized waiver, opioid overdose deaths declined by 79 percent over a four-year period."*	This legislation fails to address key differences between France and the model that would be created in the U.S. as a result of this legislation. **In France, pharmacies can only dispense buprenorphine for seven days at a time.** Physicians must specifically justify a longer duration. No such limits exist in the U.S. where schedule III drugs like buprenorphine can be refilled up to 5 times without requiring a new prescription. **Pharmacies in France supervise administration** for the induction period and for some time beyond. U.S. pharmacies are not equipped to oversee daily administration of medication. Also, widespread co-prescribing of benzodiazepines in France suggests a need for more practitioner training: "***further efforts to improve the safety of buprenorphine are warranted**, and potential means for achieving this goal in France include **increased control of buprenorphine prescriptions**, **physician training** on the risks of excessive dosing and co-prescription of other psychotropics with buprenorphine (especially benzodiazepines)*"[ix] **Exactly what this legislation would remove.**

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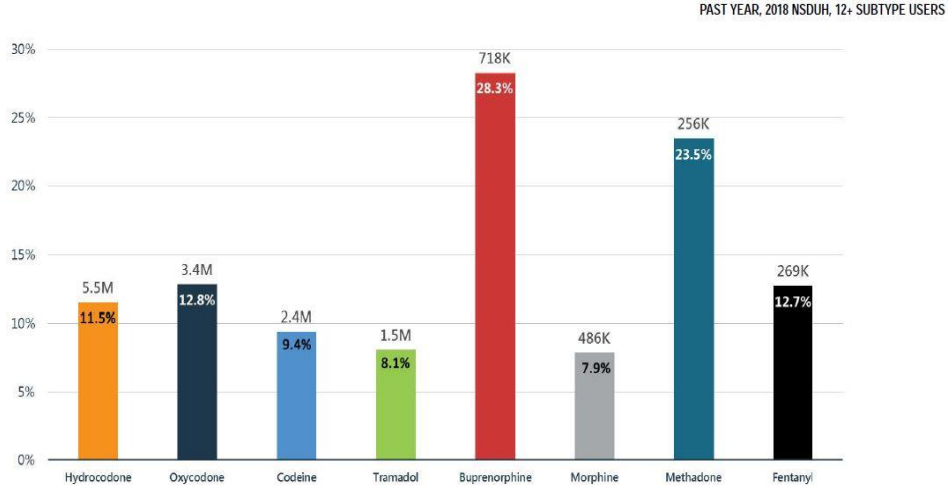
Misuse of Pain Reliever Subtypes in 2018 among Persons Aged 12 and Up[x]



[i] https://journals.lww.com/journaladdictionmedicine/abstract/9000/evidence_of_buprenorphine_precipitated_withdrawal.98967.aspx

[ii] T McLellan, A & O. Arndt, Isabelle & Metzger, David & Woody, George & O'Brien, Charles. (1993). The Effects of Psychosocial Services in Substance-Abuse Treatment. JAMA: the journal of the American Medical Association. 269. 1953-9. 10.3109/10884609309149701

[iii] Principles of Effective Treatment, A Research Based Guide (3rd Edition), National Institute on Drug Abuse, last update January 2018

[iv] Practitioner and Program Data, SAMHSA

[v] The SAMHSA Evaluation of the Impact of the DATA Waiver Program, Summary Report, March 30, 2006

[vi] Co-morbidity: Substance Use and Other Mental Disorders https://www.drugabuse.gov/sites/default/files/infographic-comorbidity.pdf

[vii] Lofwall, M.R, Walsh, S. L. 2014. A review of buprenorphine diversion and misuse: the current evidence base and experiences from around the world. *Journal of Addiction Medicine.* Sep-Oct;8(5):315-26.

[viii] Treatment Center Programs Combined, 2008-2018, RADARS® (Researched Abuse Diversion Addiction Related)

[ix] Auriacombe M, Fatseas M, Dubernet J, et al. French field experience with buprenorphine. American Journal on Addictions. 2004;13:S17–28

[x] The National Survey on Drug Use and Health: 2018, SAMHSA