AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 17, 2024

The Honorable Paul Tonko
U.S. House of Representatives
2369 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Michael Turner
U.S. House of Representatives
2183 Rayburn House Office Building
Washington, D.C. 20515

Dear Representatives Tonko and Turner:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write in response to your recent letter inquiring about the AAFP's existing actions and plans to eliminate barriers for accessing medications for opioid use disorder (MOUD).

Family physicians provide comprehensive health care to patients of all ages, are tuned in to the needs of their community, and form long-standing relationships with their patients. Given the scope of the specialty and geographic distribution, they are in an ideal position to integrate early substance use disorder (SUD) prevention services; utilize screening, brief intervention, and referral to treatment (SBIRT) for OUDs; and implement MOUD and other appropriate treatment. By doing so, family physicians play a critical role in the prevention and treatment of OUD, especially in rural and under-resourced communities. In fact, a 2020 Medicare claims study found that family medicine had the highest volume of buprenorphine prescribers of the specialties included – but also the biggest room for growth as 97.6% of Medicare-participating family physicians were not buprenorphine prescribers.[i]

The Academy is proud to have been a strong advocate in support of your legislation, the *Mainstreaming Addiction Treatment (MAT) Act*, as we shared the belief that the burdensome, redundant requirements to receive an X-waiver to prescribe buprenorphine created barriers to offering MOUD in physician practices and worsened access to this evidence-based treatment. We enthusiastically applauded its passage and ultimate enactment in 2023. However, like you, we recognize that there is still significant work to be done even with the removal of the X-waiver requirements to ensure that all individuals who need MOUD can access it readily, including from their family physician.

In response to your provided questions, the AAFP offers the following information:

1. **What are you doing to educate your members about the change in the law after the MAT Act?**

After passage of the *Consolidation Appropriations Act, 2023* and subsequent implementation of its provisions in early 2023, the AAFP began disseminating written communications to our members through a variety of channels, including our social media platforms such as X (formerly Twitter) and the Academy's website. Our website has a living FAQ resource that summarizes the new training requirements for all prescribers of controlled substances (as required by the *Medication Access and Treatment Expansion Act* or MATE Act), which also highlights the removal of the X-waiver.

2. **What are you doing to reduce stigma around MOUD and increase access?**

The AAFP recognizes that there has been a long-standing need to change the language we use when discussing and caring for patients, which is one of the ways we have been working to reduce stigma and increase access to appropriate treatment. This includes by acknowledging that OUD is a chronic condition that falls within the scope of practice for family physicians to treat. Family physicians work with patients to manage their diabetes, hypertension, and arthritis – OUD should be no different. As with any chronic condition, family physicians should strive to connect patients with the most appropriate, evidence-based treatment. Ensuring patients can refill their MOUD prescription in the same visit that they receive a COVID vaccine, get a rash examined, or have a flu test done helps destigmatize OUD and seeking treatment for it.

To help family physicians feel comfortable and equipped in their practices to treat OUD and prescribe MOUD, the Academy released a practice manual in 2021 titled "Treating Opioid Use Disorder as a Chronic Condition." The manual includes recommended language and sample conversation starters to help physicians reduce stigma and bias when treating patients with OUD, such as using "withdrawal management" instead of "detoxification." It also emphasizes the role of health-related social needs and equity considerations to be made when caring for patients with OUD.

The Academy also offers free continuing medical education (CME) to our members on substance use disorders with an emphasis on creating a non-stigmatizing, trauma-informed approach to treatment and recovery. The course explores, among other issues, patient-centered approaches with a focus on destigmatizing language and harm-reduction philosophy to caring for patients and communities. It specifically includes sessions on harm reduction and reducing stigma and treating OUD with buprenorphine, both initiation and maintenance.

3. What would you like to see changed to better incentivize access to MOUD?

A systematic review published in July found that physicians are reluctant to address substance use and addiction in their practices because of lack of institutional support, knowledge and skills, and cognitive capacity.[ii] Lack of institutional support includes lack of trained staff or resources to train staff, clinician backup, and staff time required for prior authorizations. The review specifically noted that "[p]hysician reimbursement was viewed as insufficient to cover both the staff time necessary to intervene in addiction and the expense of additional staff training."[iii] Lack of cognitive capacity was defined as "a general sense of overwhelm with clinical tasks," "the need to prioritize patients' competing needs," and the expectation by some physicians that "meeting the care needs of patients with addiction [would] be too time-consuming."[iv]

These findings expose existing flaws in our payment and coverage structures, which fail to appropriately compensate primary care physicians for the value of the work they do and the trusting relationships they establish with patients over time. This inadequate and complex payment system makes it extremely difficult, particularly for small and independent practices, to invest in the necessary staff and resources to deliver MOUD and other behavioral health services in their practice. Current fee-for-service (FFS) payment systems prioritize volume of services over the value of care delivered, pushing clinicians to see as many patients as possible. This frequently leaves them unable to dedicate the requisite amount of time for each visit to thoroughly manage and treat patients with chronic conditions, including OUD. Thus**, the Academy believes that payment reform is greatly needed to better incentivize access to and delivery of MOUD**. We provide more robust insights on these barriers and opportunities for reform below in response to questions five, six, and seven.

Family physicians have also cited continued challenges with insurance formularies and coverage of MOUD. For example, most plans cover sublingual buprenorphine, but some physicians have indicated that many patients prefer other forms, such as subcutaneous extended release or subdermal implants. Ensuring that patients are able to affordably access their preferred version of this lifesaving medication is critical for proper treatment adherence. Some family physicians have also anecdotally shared that their patients encounter significant trouble getting buprenorphine prescriptions filled at pharmacies and have to search for other pharmacies that will fill it, further delaying patients' ability to access their medication. A prescription doesn't do a patient any good if the medications are not being stocked.

While we appreciate steps Congress has taken in recent years to ensure better, more consistent coverage of MOUD, such as requiring state Medicaid programs to permanently cover certain MOUD and related counseling services, the AAFP believes there are still remaining issues to be addressed that would incentivize greater access. **This includes, as a starting point, requiring more payers to cover a patient's preferred form of buprenorphine.**

Finally, research suggests that most of the public is unaware that primary care physicians can – and do – deliver MOUD.[v] While the onus is generally on practices and clinicians to communicate the availability of services and screen patients for OUD as appropriate, there seems to be a need for additional education amongst the general public about the opportunity to receive treatment for OUD within a primary care setting. As one survey noted, **greater awareness about MOUD availability in primary care settings may increase demand and incentivize more primary care physicians to offer MOUD, especially if accompanied by clinical and administrative support**.[vi] Public awareness campaigns such as the Center for Disease Control and Prevention's Tips from Former Smokers, which increases awareness of tobacco cessation resources, and COVID-19 vaccine dissemination which identified and directed patients to the settings where they could access vaccines could serve as potential models to draw upon.

4. What resources would help your members feel confident in prescribing MOUD?

Family physicians have indicated that there continues to be an ongoing need for training and educational resources about caring for patients with OUD, including further information on treatment with or without MOUD. It seems that mid-to-late career family physicians in particular stand to benefit from additional skills training and educational resources on this topic. An analysis of data from the American Board of Family Medicine found that the percent of graduating residents and early-career family physicians who intend, or are, prescribing buprenorphine is higher than that of those who are mid-to-late career.[vii] That number is also increasing, which indicates that early career family physicians may be more likely to prescribe as addiction medicine training is becoming more common in family medicine residencies.

Anecdotally, some members have suggested that there are opportunities to provide more targeted, individualized outreach to physicians instead of relying on them to seek out information proactively, particularly in communities that have been significantly impacted by the opioid crisis. In general, resources that underscore how manageable and safe it is for family physicians to prescribe MOUD and care for patients with OUD would be beneficial.

5. What role do you believe reimbursements can play in increasing access to MOUD?

As briefly mentioned above, **payment structures that more appropriately value and pay for comprehensive primary care, including the delivery of behavioral health and SUD services, are necessary to increase access to MOUD**. The AAFP has advocated for payment models that enable physicians to provide patient-centered, compassionate care in the treatment of OUD and to appropriately compensate them for providing such care, with adequate payment for the increased time, staff, and regulatory commitments associated with delivering care for patients with OUD.

Family physicians regularly cite the lack of sufficient payment for the technology, infrastructure, and staffing as a barrier to implementing and maintaining integrated behavioral health across a wide range of primary care practice settings. Compassionately and comprehensively caring for a patient with OUD is not limited to just having a physician prescribe MOUD. It requires a multidisciplinary care team comprised of certified peer recovery specialists, social workers, behavioral health clinicians, trauma-informed care nurses, and others who can deliver additional services in addition to pharmacological treatment, such as patient education and navigation, chronic care management, harm reduction, counseling, and therapy that are critical components of helping and understanding patients with addiction.

Unfortunately, much of this work – which is also fundamental to the delivery of comprehensive, patient-centered primary care – is either poorly paid for or not captured at all in existing fee-for-service payment systems. To integrate behavioral health, many practices ultimately rely on grants or are forced to reappropriate other funds, which makes it difficult to sustain the model over the long-term.

Value-based payment arrangements that incorporate prospective payments or capitation allow physicians the flexibility needed to tailor their practice to meet their patients' behavioral health needs. This is one of the reasons why the AAFP has strongly advocated in support of the transition to value-based payment using alternative payment models (APMs) that provide prospective, predictable revenue streams. We strongly believe well-designed APMs provide primary care a path out of the under-valued and overly burdensome fee-for-service payment system that exists today and, in turn, will better enable practices to meet their patients' needs in responsive and innovative ways.

However, while some promising primary care APMs are being tested, they are largely built upon a FFS foundation, generally do not encompass integrated behavioral health services, are not aligned across payers, and are not widely or permanently available. Thus, most physicians are still paid via FFS. To advance the successful integration of behavioral health and primary care, it is also necessary to modernize FFS payment.

6. Should prior authorization be eliminated for MOUD?

Yes. Family physicians have indicated that any delay in a prescription being filled – whether due to prior authorization requirements or lack of formulary and coverage transparency – tends to cause patients to disengage from OUD treatment. The AAFP believes that a physician's attestation of a clinical diagnosis or order should be sufficient documentation of medical necessity for clinical services and medications. Prior authorization requirements create significant barriers for family physicians to deliver timely, evidence-based patient care by delaying the start or continuation of necessary treatment, including MOUD. These delays lower adherence to recommended treatments, which can lead to adverse health consequences for patients.

7. Are there existing barriers you think we should be aware of that impact your members ability to increase patient access to MOUD?

Research has shown that behavioral health, including mental health, being integrated in a primary care practice setting has been positively associated with prescribing of buprenorphine.[viii] This is presumably for the reasons described above; integrated behavioral health implies that practices already have the necessary infrastructure, resources, and staff in place to comprehensively care for a patient with OUD. Thus, **increasing the availability of integrated behavioral health in primary care practices is key to increasing patient access to MOUD**. Unfortunately, while many family physicians want to integrate behavioral health services in their practices, they face burdensome start-up costs and payment and reporting challenges that prevent integration.

The AAFP has continuously advocated for additional federal investments to initiate and sustain behavioral health integration (BHI) in primary care practices. We have supported several policies that would address some of the remaining payment-related barriers facing family physicians, including **establishment of a Medicare add-on code for office visits provided by primary care physicians who have integrated behavioral health into their practice, as proposed in the *Better Mental Health Care for Americans Act* (S. 923)**. The add-on code would be applied to evaluation and management (E/M) visits when the physician or practice has the ability to provide integrated behavioral health care, regardless of whether the patient seen is diagnosed with a mental health condition or received specific mental health care. The add-on code is designed to sustain the infrastructure components that are not completely paid by the BHI and E/M codes, thus physicians would still bill the appropriate BHI or collaborative care model code when code-appropriate services are rendered. Payment for the add-on code should be exempt from the budget neutrality requirements of the fee schedule.

Further, the AAFP appreciates and shares the vision of the MATE Act in ensuring that all prescribers of controlled substances receive appropriate education and training to enhance their knowledge of and comfort with treating patients with OUD, including prescribing MOUD. However, **its implementation in tandem with the removal of the X-waiver has been particularly challenging for family physicians and the AAFP.**

The AAFP, through the AAFP Credit System, accredits other organizations' trainings, including many that are closely aligned with the Substance Abuse and Mental Health Services Administration's (SAMHSA) guidance for MATE-compliant trainings, that are specifically tailored for primary care, family medicine, and non-physicians who work with family physicians. The AAFP Credit System has certified individual CME activities since 1948**. AAFP-accredited CME activities account for 68,050 current AAFP members that have already completed eight hours/credits or more of education on management of patients with OUD/SUD and safe prescribing since 2017.** Additionally, the AAFP has approved over 4,000 educational sessions with over 9 million credits in these topic areas since 2020.

Unfortunately, due to interpretation of the statute by SAMHSA and the Drug Enforcement Agency (DEA) and their decision to not proceed with statutorily-authorized rulemaking, AAFP accredited trainings were not deemed compliant. As a result, thousands of family physicians and other clinicians have already had to or will soon be required to retake CME courses that are either duplicative of past trainings or not pertinent to their practice, patient population, and specialty. They will need to take time away from their patients or risk losing the ability to prescribe medications for their patients — both of which are contrary to the MATE Act's original goal of improving SUD screening and treatment. This result is an unnecessary and significant

time and administrative burden on family physicians and is not aligned with congressional intent of the statute.

In 2023, sponsors of the MATE Act sent a letter of congressional intent to SAMHSA. However, in their response, SAMHSA indicated that they would still not be undergoing rulemaking to recognize additional entities. This has left Congressional action as the only remaining pathway to resolve this issue that is undermining the very goals of the MAT and MATE Acts.

The Academy has worked closely with MATE Act sponsors to ensure the inclusion of language in both the House and Senate versions of the *SUPPORT Reauthorization Act* (Section 205 in H.R. 4531 and Section 403 in 3393) that would address this barrier by explicitly recognizing trainings both provided by and/or accredited by the AAFP as being compliant. However, as you know, the SUPPORT Act has already expired in Congress and progress advancing its successor legislation has unfortunately stalled. As Congress resumes for the post-election work period**, we would greatly appreciate your continued advocacy amongst your colleagues and to Congressional leadership to ensure its passage is prioritized prior to the closure of the 118th Congress.**

8. Are there actions you need Congress to take that would in turn allow your members to expand access to MOUD?

The AAFP continues to advocate for long-term behavioral health care improvements, like more resources to integrate behavioral health care into primary care settings and improve crisis response and stabilization care. However, these improvements must be accompanied by more immediate action to improve access to lifesaving MOUD treatment.

Prior to the COVID-19 public health emergency (PHE), the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 required patients to receive an in-person medical evaluation to receive a prescription for a controlled medication. While this requirement was put in place to prevent illegal distribution and diversion of controlled substances over the internet, it also prevented physicians and other clinicians from prescribing MOUD and other controlled substances during a telehealth encounter.

The AAFP applauded actions taken by SAMHSA and DEA during the COVID-19 PHE that allowed physicians to temporarily prescribe buprenorphine and initiate treatment via telehealth and audio-only visits. These flexibilities allowed more physicians, including those outside of opioid treatment programs (OTPs), to provide MOUD. As a result, studies showed that telehealth-only treatment of OUD using buprenorphine, including audio-only, increased treatment retention and reduced illicit opioid use when compared to those using in-person treatment options.[ix,x] This was true across demographics and geographic locations.[xi] Telehealth and audio-only initiation of and continued treatment with buprenorphine was also associated with higher patient satisfaction, lower health care costs, and improved access to treatment.[xii]

The in-person connection between a physician and patient can be a valuable touchpoint for patients receiving MOUD and other OUD treatment services. However, existing shortages of clinicians prescribing buprenorphine for OUD, as well as numerous other barriers faced by patients with OUD, prevents many patients from being able to obtain an in-person visit. While an in-person evaluation is often necessary for other primary care services, the data cited previously shows that buprenorphine prescribing is particularly well-suited for virtual-only visits. Allowing physicians to continue prescribing buprenorphine via telehealth affords them greater autonomy

in their clinical decision-making and the ability to provide care through the most appropriate modality for each interaction, as determined by them and the patient.

We have advocated for these flexibilities to be made permanent and supported SAMHSA's finalization of a rule earlier this year that allows registered OTPs to permanently continue telehealth and audio-only prescribing of buprenorphine. However, DEA has continued to delay publication of final regulations that would clarify the ability for individual physicians and other clinicians to continue providing MOUD treatment via telehealth permanently now that the PHE has ended. Without regulatory or Congressional intervention, the flexibilities will expire at the end of this year.

In the absence of well-designed, evidence-based regulatory action, **the AAFP strongly urges Congress to take steps to ensure that physicians can continue to prescribe buprenorphine and initiate treatment through whatever modality is most appropriate for each individual patient, including telehealth and audio-only**. To that end, we have endorsed the *Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act* (H.R. 5163 / S. 3193), which would permanently waive the in-person exam requirement for prescribing medication via telemedicine for people with OUD, and we would encourage Congress to prioritize its passage before the flexibilities expire at the end of this year.

Thank you for your outreach on this critically important issue. The AAFP has appreciated your consistent leadership to address our nation's opioid crisis. We look forward to continuing to partner with you to ensure more family physicians can comprehensively care for patients with OUD, including prescribing MOUD. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

R. Shawn Martin
Executive Vice President and CEO, American Academy of Family Physicians

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