American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

December 11, 2024

The Honorable Paul Tonko
U.S. House of Representatives
2369 Rayburn House Office Building
Washington, DC 20510

The Honorable Mike Turner
U.S. House of Representatives
2183 Rayburn House Office Building
Washington, DC 20510

Dear Representative Tonko and Representative Turner,

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for your ongoing commitment to addressing the opioid crisis and supporting policies that improve access to life-saving treatments for opioid use disorder (OUD). We appreciate your leadership in authoring and championing the Mainstreaming Addiction Treatment (MAT) Act, which was an essential step forward in eliminating barriers to medication for opioid use disorder (MOUD). As emergency physicians on the frontlines, we witness daily the devastating consequences of OUD and substance use disorder and are committed to ensuring that those who need treatment can access it, especially those who require emergency care.

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As you well know, after two decades of steadily increasing rates of opioid overdose deaths, recent data from the Centers for Disease Control and Prevention (CDC) indicates a substantial decrease in opioid-related overdose deaths. While this shift marks a significant turnaround compared to previous years, overall rates of opioid overdose deaths remain high and it is still not entirely clear whether this decline will continue, nor is there certainty about what policies or factors may have contributed to the decline. While policies like the MAT Act have helped reduce the stigma of and barriers to treatment for OUD and significantly expanded the pool of medical professionals able to prescribe buprenorphine, ACEP recognizes that further work is needed to increase MOUD access and tackle remaining barriers in order to ensure this downward trend continues. We welcome the opportunity to respond to your questions and provide insight into how ACEP and our members are addressing this issue.

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

ACEP has prioritized educating our members on the repeal of the X-waiver and the broader implications of the MAT Act through multiple channels and member resources.

- ACEP's Pain Management and Addiction Medicine Section has been active in promoting these resources to emergency physicians through webinars, clinical guidelines, and continuing medical education-credited programs.
- ACEP also created a Medication Assisted Treatment (MAT) FAQs resource to inform interested physicians about documentation needed to prescribe MOUD medications, reporting requirements, reimbursement information, and provide them with answers to other questions they may have.
- ACEP has produced webinars on topics like "ED-Initiated Buprenorphine", "Buprenorphine Induction in the ED", and to help emergency physicians transition into new prescribing practices with confidence.
- ACEP approved Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department.

- The treatment of opioid use disorder (OUD) with medications like methadone and buprenorphine significantly reduces morbidity, mortality, and opioid use while improving patient outcomes such as quality of life and retention in care.
- ACEP has disseminated materials on best practices for prescribing buprenorphine in the emergency department (ED) and has hosted sessions at our national conferences to ensure that our members are well-equipped to implement these changes.

Overall, the resources are aimed at providing clear, actionable information on how to integrate MOUD into ED practices.

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

Collectively, we have made important progress to reduce stigma and eliminate barriers to treatment, but there is still a hesitancy around specifically prescribing buprenorphine and a lack of awareness by some of the legal changes established under the MAT Act. ACEP recognizes that stigma remains one of the largest barriers to treating OUD effectively, and we have worked to encourage emergency physicians to view MOUD as a first-line treatment for patients in crisis. This effort includes public awareness campaigns aimed at both health care providers and the general public, as well as internal initiatives to normalize the prescription of buprenorphine in emergency settings.

We also continue to engage with key stakeholders, including federal agencies like the U.S. Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA), to address both regulatory and perception-based barriers to MOUD access. The ACEP Public Health & Injury Prevention Committee, which works to examine and analyze the role of emergency medicine in public health in areas such as health promotion, prevention and management of infectious diseases, and the prevention and control of violence and injuries, also developed an information paper, "Stigma in the Emergency Department," to provide emergency physicians with practical advice on how to promote the end of stigmatization in the ED. While this is a broader resource and not specific solely to MOUD, it does include sections to better inform emergency physicians when engaging with and caring for patients with substance use disorder or those who are in recovery.

Addressing stigma and improving access to MOUD for our patients has been a longstanding priority for ACEP and remains so. In January 2020, ACEP convened a summit, "Addressing the Opioid Stigma in the Emergency Department." The summit gathered a diverse group of organizations and representatives to discuss and share ideas to gain insight into the prevalence, effect, and targeted solutions to limit the impact of stigma on the care of ED patients with opioid use disorder (OUD). Through targeted breakout sessions that developed specific recommendations based on consensus, attendees developed concrete strategies to reduce stigma and improve the experience for ED patients with opioid use. Attendees used examples from ED patients with OUD and recommendations for previously implemented successful strategies from other professional organizations to develop these strategies. Following the summit, ACEP in partnership with Opioid Response Network published "Ending Stigma of Opioid Use Disorder," an educational video that provides firsthand testimony from patients living with OUD and physicians who have seen and experienced stigma surrounding OUD and treatment.

In 2021, ACEP also hosted an Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop. The workshop covered key topics such as setting up an ED-based Buprenorphine and Naloxone program, strategies for reducing stigma around opioid use disorder, and effective approaches to pain management in emergency departments. As part of the Opioid Response Network, ACEP continues to work on combating stigma through education, targeted interventions, and ongoing research.

ACEP's participation in the National Academy of Medicine (NAM) Action Collaborative on Countering the U.S. Opioid Epidemic focuses on developing tools and resources to address stigma at the national level. This collaborative aims to promote policies and guidelines that standardize addiction treatment, making it more accessible and less stigmatized. ACEP's E-QUAL Network Opioid Initiative also promotes harm reduction strategies, such as naloxone distribution and safe prescribing practices, which further integrate addiction treatment into everyday emergency care.

ACEP also supports the funding and operation of overdose prevention centers (OPCs) as health care facilities that reduce harm, improve treatment access, and save lives. ACEP highlights the decades of evidence showing OPCs' efficacy in reducing infectious disease transmission, engaging individuals in treatment, and preserving community medical and

financial resources. ACEP continues to advocate for research that evaluates OPCs' impact on public health and overdose trends, engages community stakeholders, and identifies harm reduction metrics beyond abstinence. ACEP also emphasizes the need for policies protecting OPCs and their participants from legal risks while ensuring sustainable funding and reimbursement structures.

In August 2022, ACEP also launched the EM Opioid Advisory Network. This initiative was formed by leaders and experts from the Pain Management & Addiction Medicine Section and the Pain & Addiction Care in the Emergency Department (PACED) accreditation program, that connected emergency physicians combating the opioid crisis with expert advice on managing Opioid Use Disorder patients presenting in the ED, creating a protocol to initiate buprenorphine, and more. In addition, ACEP works with the State Targeted Response Technical Assistance Consortium (STR-TA) to provide localized assistance, ensuring that hospitals and emergency departments have access to best practices and clinical support systems for MOUD.

In June 2020, the ACEP Board approved the clinical policy, "Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department," and in February 2021, the ACEP Board of Directors approved the "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." These recommendations encourage emergency physicians offer to initiate OUD treatment with buprenorphine in appropriate patients and provide direct linkage to ongoing treatment for patients with untreated OUD, and provide strategies for OUD treatment initiation and ED program implementation, including harm reduction strategies (including overdose education and naloxone distribution) or prescriptions as an essential component of the ED visit.

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

One key change that would incentivize greater access to MOUD is increasing reimbursement rates for MOUD-related services in emergency settings. Emergency physicians are often the first point of contact for individuals suffering from opioid overdoses, and incentivizing buprenorphine initiation in the ED could lead to better long-term outcomes. Additionally, policies that provide reimbursement for the follow-up care and wraparound services necessary for sustained recovery are essential.

Initiating buprenorphine in the ED is a critical tool to help an individual begin their path to recovery, but ensuring access to the longer-term treatment they need and deserve is necessary to support them throughout the process. In a survey published by RAND in 2022, researchers examined records that capture 92% of prescriptions filled at U.S. retail pharmacies, identifying buprenorphine prescriptions written by emergency physicians and filled between February 1, 2019, and November 30, 2020. The study found that during 2019 to 2020, 71.5% of patients filling buprenorphine prescriptions written by emergency physicians did not fill subsequent buprenorphine prescriptions from other clinicians. That trend was even greater after the declaration of the COVID-19 public health emergency. ACEP recommends a direct referral or scheduling an appointment with a prescriber who accepts the patient's insurance after a buprenorphine prescription is given to a patient in an emergency department. However, this approach works only if the local clinicians are accepting new buprenorphine patients, and studies suggest that many buprenorphine-prescribing clinicians are not treating many patients or are not accepting new ones.

Contributing to these challenges is that many emergency departments do not stock buprenorphine and are not required to stock buprenorphine and other medications for opioid use disorder (MOUD) by accrediting bodies or government agencies. Further, as discussed in greater detail below about existing barriers that affect our members' ability to increase patient access to MOUD, since buprenorphine is classified as a "suspicious order" according to current DEA regulations, many community pharmacies are hesitant to stock buprenorphine and there is a misperception that there are limits on how much of the medication pharmacies may carry at any one time. Strategies to improve access to treatment for patients with OUD include adding buprenorphine to the FDA's list of essential medicines list to help ensure adequate supply within hospitals, as well as removing buprenorphine from the Suspicious Orders Report System (SORS) to address concerns pharmacies may have about stocking buprenorphine.

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

ACEP believes that real-time access to addiction medicine specialists through consultation hotlines, continued CME opportunities, and integration of buprenorphine into clinical decision-making tools would help our members feel more

confident in prescribing MOUD. Furthermore, we urge the development of streamlined systems to connect patients to follow-up care post-discharge, reducing the burden on emergency physicians to ensure long-term treatment adherence.

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

Emergency physicians must be supported through appropriate reimbursement for both the initial administration of MOUD and follow-up care coordination. Value-based payment models that reward positive patient outcomes could drive further adoption of MOUD, particularly if they recognize the unique role of emergency departments in initiating treatment. ACEP members are encouraged, but *not* financially incentivized, to support patient navigation from local behavioral health and public health departments and increase volume to local treatment clinics. Specifically, billing for buprenorphine in the emergency departments utilizes HCPCS code G2213 for the initiation of medication for treatment of opioid use disorder in the emergency department setting, which includes assessment, referral to ongoing care, and arranging access to supportive services. The G-code is reimbursed by Medicare, many state programs, and some commercial payers. However, ensuring there is an adequate rate of reimbursement is imperative. By eliminating financial barriers to lifesaving treatments, we can provide our patients who have overdosed or who are at risk of overdose with the opportunity to continue their path to recovery – an opportunity they may not otherwise have had.

Additionally, research shows that patient navigation for substance use disorder (SUD) and co-occurring mental illness is a cost-effective intervention. If patients are treated in the ED and moved to an outpatient setting, hospitals can help reduce their utilization, decreasing costs by more than $17,000 per patient. In other words, SUD navigation reduces costs for hospital through decreased inpatient admission rates and repeat ED visits.

There are existing programs that have helped ensure patient access to proper medication and support. For example, ScalaNW, a program in Washington state that provides evidence-based protocols, real-time 24/7 clinical support, and assistance with follow-up care scheduling through the Washington Recovery Helpline. Hospitals in the network also receive help with policies, billing, and education to better implement MOUD. This type of integrated system could serve as a model for expanding access in other states, especially in areas where pharmacies are not readily stocked with buprenorphine.

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

One of the most significant barriers is the inconsistent availability of buprenorphine in community and hospital pharmacies. As mentioned, many pharmacies are not stocking buprenorphine due to quotas or caps imposed by distributors, which are influenced by DEA's Suspicious Orders Report System (SORS) database. These quotas often flag buprenorphine orders as "suspicious," deterring pharmacies from carrying the medication. With distributors hesitant to ship, and pharmacies reluctant to stock, the medication in the quantities needed often fails to meet the growing demand, exacerbating the challenges already faced by individuals in crisis. One study indicated that due to these reporting requirements, less than two-thirds of surveyed pharmacies reported stocking the medication, a stark contrast to how other chronic illness medications are handled.

ACEP has raised this issue directly with the DEA and advocated for policy changes that would exempt buprenorphine from these suspicious order classifications. To this end, ACEP strongly supports the Broadening Utilization of Proven and Effective Treatment (BUPE) for Recovery Act (H.R. 9886/S. 5271) to temporarily exempt buprenorphine from SORS during the opioid public health emergency, allowing patients to access the medication without unnecessary delays. Additionally, some of our members have suggested that the interpretation of federal opioid settlement restrictions and their impact on distribution algorithms continue to limit access to MOUD, and that the U.S. Department of Justice or DEA could help by ensuring that the language in those settlement policies be consistent with the BUPE for Recovery Act or any related revisions to SORS.

A significant barrier also exists for methadone which, unlike buprenorphine, can only be dispensed by opioid treatment programs (OTPs). Federal regulations require hospitals to start patients on low methadone doses for withdrawal management, but they must then refer patients to OTPs, which are often difficult to access, particularly in rural areas. Hospitals can provide a three-day supply of methadone to bridge the gap before a patient can be seen at an OTP, but this

process remains logistically challenging for providers and patients. More flexibility in methadone regulations, along with expanded OTP availability, could improve access to this critical medication.

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

We urge Congress to continue advancing legislation that supports and expands access to MOUD by addressing supply chain and reimbursement challenges. Beyond the aforementioned BUPE for Recovery Act, ACEP encourages Congress to advance policies that provide increased funding to support broader education of MOUD requirements for clinicians and ensure that emergency departments have the necessary resources to initiate and sustain MOUD programs.

There is no one-size-fits-all solution that will solve the crisis, but fortunately, we have a growing array of tools that we can use in our efforts to address this public health challenge and continue to the downward trend in deaths. This includes opioid overdose reversal agents, such as naloxone, that when used properly can rapidly reverse an overdose and can be easily administered by family members, bystanders, or other laypeople without any training required. ACEP advocates for increased access to naloxone and education for its appropriate use. Preemptively providing naloxone to patients at risk of opioid overdose, along with greater education and awareness about overdose treatment, helps reduce overdose deaths in our communities. To that end, ACEP supports the "Hospitals as Naloxone Distribution Sites (HANDS) Act" (H.R. 5506) which aims to address the opioid and substance use disorder (OUD/SUD) crisis by ensuring that opioid overdose reversal agents like naloxone are made available at no cost under Medicare, Medicaid, and TRICARE. The bill focuses on preventing overdose deaths by eliminating financial barriers to naloxone distribution in hospitals, particularly for patients at risk of opioid overdose. This would enable emergency physicians to preemptively provide naloxone, empowering patients, their families, and communities to administer the life-saving drug during overdose situations.

Congress should also reauthorize and appropriate funding for the "Preventing Overdoses While in Emergency Rooms (POWER) Act" that was originally enacted as a provision in the comprehensive SUPPORT for Patients and Communities Act (P.L. 115-271). The POWER Act will help address opioid overdoses by equipping emergency departments with the tools and protocols needed to prevent recurrent overdoses. It encourages hospitals to initiate treatment for OUD in the emergency room and helps transition patients to long-term treatment programs. The program establishes best practices and procedures for treating patients who present to the emergency department with an overdose or suspected overdose, and ensuring a "warm hand-off" to appropriate referral, transfer to, or coordination with longer-term care and treatment options within the community in order to support their long term recovery, prevent relapse, and reduce recidivism and future overdose. It also promotes the use of peer recovery coaches and provides funding for hospitals to improve follow-up care, aiming to reduce overdose fatalities and foster long-term recovery for patients. While this program was originally authorized as part of the SUPPORT Act, it never received federal funding and as a result was not included as part of the efforts to reauthorize expiring SUPPORT programs in the 118th. However, with appropriate support, we remain confident that this program would be a valuable asset in our collective efforts to prevent overdoses.

Another important legislative solution Congress should consider for expanding access to MOUD is the "Modernizing Opioid Treatment Access Act (H.R. 1359/S. 644)." The bill seeks to broaden access to methadone for opioid use disorder (OUD) by allowing pharmacies to dispense methadone for OUD, a service currently limited to highly regulated opioid treatment programs (OTPs). The bill would also allow board-certified physicians in addiction medicine or psychiatry, who are not affiliated with OTPs, to prescribe take-home doses of methadone for OUD patients. These changes aim to reduce the barriers to accessing methadone, especially for those living in areas with limited or no OTPs, such as rural or underserved communities.

Congress should continue to support and fully fund the ACEP-developed Emergency Department Alternatives to Opioids (ALTO) program. Through this program, originally enacted as part of the SUPPORT Act in 2018 and reauthorized in 2022, 27 grants have been awarded thus far to help hospitals across the country expand the implementation of ALTO protocols and increase their use of non-opioid alternatives in emergency department. These grants help hospitals to develop, implement, and improve protocols that reduce opioid use for pain management, focusing on evidence-based alternatives. By reducing opioid prescriptions in emergency settings, the ALTO Act seeks to prevent addiction and promote safer pain management practices.

Finally, the flexibility to prescribe controlled substances via telehealth, first introduced during the 2020 public health

emergency (PHE), has been a critical tool for expanding access to treatment for. Under temporary exceptions to the Ryan Haight Act, clinicians have been able to prescribe medications like buprenorphine without requiring an in-person evaluation, ensuring that patients in rural, underserved, or stigmatized populations could access care. Although a final rule has not been issued, the Department of Health and Human Services recently announced temporary extensions through the end of 2025. Making these changes permanent would remove unnecessary barriers, allowing clinicians to provide life-saving treatments to patients who may otherwise have no viable options for care. Expanding these telehealth capabilities would support emergency physicians' efforts to reach more patients, reduce overdose deaths, and address the opioid crisis comprehensively.

Once again, thank you for the opportunity to respond to this important request for information. ACEP shares your commitment to addressing the opioid crisis and expanding access to evidence-based treatments for OUD. We stand ready to collaborate with you and your colleagues in Congress to eliminate the remaining barriers to MOUD access and ensure that all patients receive the care they need. Should you have any questions, please do not hesitate to reach out to Ryan McBride at rmcbride@acep.org if you have further questions or require additional information.

Sincerely

Alison J. Haddock, MD, FACEP
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