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David J. Skorton, MD
President and Chief Executive Officer

June 4, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

I write on behalf of the Association of American Medical Colleges (AAMC) to thank you for the Administration's efforts to address the Coronavirus Disease 2019 (COVID-19) pandemic and to encourage the Department of Health and Human Services (HHS) to include among its responses to the pandemic a robust plan to prevent and address consequential growth in our nation's longstanding addiction epidemic. While the nation's opioid use disorder (OUD) crisis predates the current pandemic, we are concerned that the intersection of these two public health emergencies will only heighten the challenges for individuals living with substance use disorders (SUD) and chronic pain and potentially lead to greater incidence across the country.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 155 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

While AAMC-member teaching hospitals represent only five percent of all hospitals, they have been the cornerstone of the nation's response to both the current pandemic and past public health crises, including the opioid epidemic. Teaching hospitals account for a substantial share of care delivered nationally – including 25% of all hospital inpatient days, 22% of all Medicare inpatient days, and 26% of all Medicaid hospitalizations – and disproportionately care for the Nation's under- and uninsured patients, accounting for 34% of charity care.[1] Major teaching hospitals also offer vital services that cannot be accessed elsewhere in the community, as has been demonstrated by their outsized role in treating confirmed and suspected cases of the novel coronavirus and their efforts to fill testing and other needs in their communities.

[1] Source: AAMC analysis of FY2018 American Hospital Association (AHA) Annual Survey Database. AAMC membership as of January 2020. Note: Data reflect short-term, general, nonfederal hospitals.

Even before the COVID-19 crisis, these institutions have served on the front lines of the country's safety net in other ways too, investing in a wide scope of mental and behavioral health services, including treatment and recovery support for substance use disorders. Half of AAMC-member teaching hospitals offer outpatient substance use services, and AAMC-member hospitals also account for 19% of the nation's alcohol unit beds and 23% of inpatient psychiatric unit beds. The vast majority of our member teaching hospitals provide child psychiatry services or outpatient psychiatric care. In short, our members have seen first-hand the devastating impacts of the opioid epidemic on patients, families, and communities.

As a result, for years, the AAMC has been actively engaged in addressing and finding solutions to the opioid epidemic, including working to assess and support our members as they work to prevent, identify, and treat pain and addiction. One year ago – in recognition of the toll that opioid misuse has been taking on patients and communities nationwide and the efforts of medical schools and teaching hospitals to leverage their research, education, and clinical care missions to reverse the epidemic – the AAMC led a National Workshop to Advance Medical Education to Combat Opioid Misuse as part of a broader AAMC initiative focused on challenges associated with pain and addiction. The workshop was an unprecedented convening of nearly 400 delegates from across nearly all of the AAMC's membership and other key stakeholders. We were pleased to receive support from the Centers for Disease Control and Prevention (CDC) and to welcome participation of leaders from several HHS agencies and other Administration officials.

In the year that has passed, participants have engaged with both AAMC and each other to drive continued change at both the local and national levels. Attendees committed to addressing local gaps and sharing exemplary works across member institutions. Medical educators are preparing the next and the current generations of physicians by enhancing existing content on pain and substance use disorders with additional classroom, hands-on, and interprofessional experiences integrated throughout the educational continuum (medical school – residency – continuing medical education). Likewise, research at medical schools and teaching hospitals continues to improve our understanding of both pain and addiction, and physicians and other health professionals at these institutions are actively advancing clinical innovations to blunt the crisis.

Today, the AAMC remains committed to these wide-ranging efforts which, together with a concerted and sustained multi-sector response, have resulted in promising decreases in death rates: Opioid-involved death rates decreased by 2% and prescription opioid-involved death rates decreased by 13.5% in 2018.[2] While we are encouraged by this progress in mortality, we are concerned that the recent COVID-19 pandemic is likely to amplify the impact of both opioid use disorder and other substance use disorders across the country. In addition, while the pandemic is affecting all Americans, it is disproportionately impacting vulnerable communities, including those with comorbidities such as OUDs and chronic pain. More than 2 million Americans are afflicted with OUD, and on average, 130 die every day due to overdose, which remains the leading cause of accidental deaths in the U.S. Due to the pandemic, harm reduction programs

[2] Wilson N, Kariisa M, Seth P, et al. Drug and Opioid-Involved Overdose Deaths—United States, 2017-2018. MMWR Morb Mortal Wkly Rep 2020; 69:290-297.

are being impacted, isolation is increased, and many experts are very concerned that COVID-19 will dramatically increase the rate of OUD and deaths by overdose.[3]

As the Administration implements additional actions to contain the current COVID-19 outbreak as well as to prevent and prepare for its potential recurrence and/or aftermath effects, we encourage you to consider **with urgency** several needed actions to mitigate the impact of the pandemic on the OUD and SUD epidemics. These include actions to expand access to evidence-based treatment, expand the physician workforce to help meet current and anticipated increasing demand for care, and ensure telehealth expansion can continue, including for treatment of OUD.

Expand access to evidence-based treatment. Patients who seek care for treatment of opioid use disorder continue to have significant difficulty in accessing treatment options that reflect the most current science. In 2018, for a variety of reasons, only 11.1% of people who needed treatment for substance use actually received it.[4] For example, studies have shown the effectiveness of buprenorphine in safely treating opioid use disorder, but a federal waiver is required to prescribe the medication. While the number of waivered clinicians has increased in recent years, still only a small fraction of physicians has completed the waiver process, leaving a limited number of clinicians able to prescribe buprenorphine despite the overwhelming demand for this evidence-based treatment. To help minimize the hurdles for qualified clinicians to provide medications for treatment of opioid use disorder, the AAMC strongly supports suspending the waiver requirement under the Drug Addiction Treatment Act of 2000. This outdated waiver disincentivizes clinicians from providing evidence-based treatment, and, furthermore, limits waivered clinicians in the number of patients they can treat.

Some have expressed concerns over physicians' exposure to educational content on addiction during and after training, particularly if the waiver requirement is suspended. Work continues to improve the education of health care professionals in treating and managing chronic pain, addiction, and opioid use disorder, and our members are making great strides in these areas with an evidence-based approach to medical education. For example, developing new or expanding existing content on medication to treat substance use disorders was among the top outcomes reported by participants in the AAMC's National Workshop last May. We are concerned that training mandates, such as the requirements under the current waiver process, set arbitrary benchmarks that do not necessarily enhance learning or safety and, worse, limit access to evidence-based care. For these reasons, we continue to strongly oppose any efforts for the federal government to dictate training requirements on this or other topics. Medical science, local community needs, and educational expertise should drive curricular content, not legislative mandates.

Alternatively, programs that offer funding opportunities for educators to develop and test teaching and learning approaches to the challenges they face will have extraordinary uptake and

[3] https://annals.org/aim/fullarticle/2764312/when-epidemics-collide-coronavirus-disease-2019-covid-19-opioid-crisis

[4] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

will always be more effective in driving meaningful change than imposing mandates. We appreciate the Administration's budget request to fund grants to medical education programs to integrate content on the use of medications to treat opioid use disorder into the curriculum and support that approach to facilitate ongoing efforts to enhance educational content in key areas.

Expand the physician workforce to help meet current and anticipated increasing demand for care. In addition to waiver restrictions, another limiting factor for access includes the overall shortage of physicians in this country. The demand for physicians continues to grow faster than supply, leading to a projected shortfall of between 46,900 and 121,900 primary care and specialty physicians by 2032 with projected shortages in both primary and specialty care. Physicians are a critical element of our health care infrastructure and workforce, and if we do not address this impending problem, patients from pediatrics to geriatrics will find it difficult to access the care they need. While this is a serious issue for all of us, it is especially problematic because of our aging population and physician retirement. A person's need for a physician increases with age, and the U.S. population aged 65 and older is predicted to grow 50% by 2030.

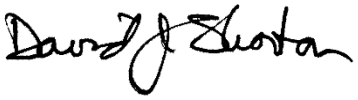
Although medical schools have expanded their class sizes to address shortages, residency positions have not grown at the same pace. We greatly appreciate the recent announcement of new funding from the Health Resources and Services Administration (HRSA) to initiate new addiction medicine fellowships, and, because physician training is a multi-year endeavor, we continue to urge additional investments that will provide the necessary predictable and reliable long-term commitment to expanding the workforce. The AAMC strongly supports legislation, including the Opioid Workforce Act (OWA, H.R. 3414/S. 2892) and the Resident Physician Shortage Reduction Act (H.R. 1763/S. 348) that would take a step toward addressing the physician shortage by gradually and responsibly increasing Medicare's two-decade cap on support for residency positions. The Resident Physician Shortage Reduction Act would enable teaching hospitals to expand their training by supporting an additional 15,000 new residency positions phased-in over five years, including an emphasis on specialties with recognized shortages in both primary and specialty care. The OWA is more targeted and would allow for growth of the addiction workforce, with new training support for addiction medicine, addiction psychiatry, and pain medicine. Together, these two bills will help us combat the opioid epidemic and better position our nation for fighting current and future pandemics.

Ensure telehealth expansion can continue. We support the recent Substance Abuse and Mental Health Services Administration (SAMHSA)'s and Drug Enforcement Agency (DEA)'s temporary change to allow "authorized practitioners" to prescribe buprenorphine to new and existing OUD patients for maintenance or detoxification treatment via telehealth examination without the need for a prior in-person visit. We urge the Administration to make this change permanent to ensure this important expansion is not limited solely to the current Public Health Emergency (PHE). We realize this change, regardless of permanence, assumes that there are clinicians who are available and "authorized" to conduct these tele-visits. We strongly believe that by eliminating the waiver requirement, increasing addiction specialists, and expanding the ability for clinicians to treat via telehealth, we will make significant progress in combatting the opioid epidemic.

Additionally, we greatly appreciate the flexibilities the Centers for Medicare and Medicaid Services (CMS) provided for telehealth coverage and payment in response to the PHE. These changes have enabled teaching hospitals, teaching physicians, other health care providers, and their patients, including individuals with substance use disorders, to experience the benefits of telehealth and, where possible, maintain access to critical and timely care. We urge that CMS make permanent the telehealth regulatory flexibilities that the COVID-19 experience has demonstrated are critical to enhancing access to care for all patients.

Once again, we appreciate your departmental leadership in recognizing the opioid epidemic as a key national priority throughout your tenure and the work of your agency- and other colleagues to address the novel COVID-19 pandemic. Given that the substance use crisis is only likely to intensify as a result of COVID-19, we think now is the critical time to implement the recommendations outlined above. We would be pleased to work with you on these efforts. Please feel free to contact me directly or AAMC Chief Public Policy Karen Fisher, J.D., at kfisher@aamc.org.

Sincerely,



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cc: The Honorable Brett Giroir, M.D., Assistant Secretary for Health
The Honorable Seema Verma, Administrator, Centers for Medicare & Medicaid Services