April 12, 2024

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United States Senator
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Washington, DC 20510

Mike Braun
United States Senator
404 Russell Senate Office Building
Washington, DC 20510

Maggie Hassan
United States Senator
324 Hart Senate Office Building
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Elizabeth Warren
United States Senator
309 Hart Senate Office Building
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Donald Norcross
Member of House of Representatives
2427 Rayburn House Office Building
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Don Bacon
Member of House of Representatives
2104 Rayburn House Office Building
Washington, DC 20515

Dear Senators Markey, Braun, Hassan and Warren, and Representatives Norcross and Bacon,

Thank you for your March 12 letter regarding expansion of access to methadone and concerns about current industry structure. We are grateful for the chance to engage on these topics because at Acadia our mission is to save and transform the lives of patients with opioid use disorder (OUD) and other complex behavioral health conditions. We are proud to treat more than 70,000 OUD patients at our OUD clinics every day, achieving 99%+ quality scores from the Commission on Accreditation of Rehabilitation Facilities (CARF) and delivering on our promise of "zero waiting lists" across our opioid treatment programs (OTPs). We appreciate your concerns, welcome the occasion to provide clarity, and thank you for the opportunity to share vital information about how we are working to confront the challenges presented by our nation's opioid overdose crisis.

We have five key considerations to share in response to your inquiries:

1. We are not a private equity entity, as your letter states. And we feel compelled to note that there are as many non-profit OTPs in the country as private equity-backed programs. Independent of company classification, Acadia's priorities are driven by our mission to save and transform the lives of our patients.
2. We wholeheartedly agree that greater access to robust medication-assisted treatment, including methadone, is needed – and Acadia has played a leadership role in this effort for many years, including by funding new clinics, mobile vans, and tech-enabled care.
3. But we echo concerns by law enforcement, experienced clinicians, state governments, former government officials, and other community stakeholders regarding the patient safety risks of the legislative proposal mentioned in your letter.
4. Further, due to multiple practical limitations, it is increasingly clear that the proposed legislation would have a disappointingly small impact on access to care, particularly in rural areas.
5. We believe that concrete actions can and should be taken to improve OUD treatment access without putting patients at risk, including via alternative policy approaches. We are playing a key leadership role in advancing many of these strategies, but we also need your help.

Next, we will share more detail on each of these areas.

Consideration 1: We are not a private equity entity, as your letter states. And we feel compelled to note that there are as many non-profit OTPs in the country as private equity-backed programs. Independent of company classification, Acadia's priorities are driven by our mission to save and transform the lives of our patients.

Acadia Healthcare is the leading standalone behavioral health provider in the U.S., operating 259 treatment facilities across 38 states and Puerto Rico. Amid the greatest behavioral health crisis in the country's history, we treat the highest-need, most complex behavioral health patients in the nation. Our mission is to save and transform the lives of these patients, and thereby strengthen our communities. In addition to the medical support provided within our facilities, we help to advance the broader health of the communities in which we serve through partnerships with groups that share our purpose to Lead Care with Light – including the Jason Foundation, the National Alliance on Mental Illness (NAMI), Safe Haven Shelter, Backfield in Motion, Musicians on Call, and other important philanthropic organizations. We are also proud of our clinical partnerships with community organizations such as Boston Healthcare for the Homeless, the UNC Health Foundation, and the North Carolina Harm Reduction Coalition Syringe Exchange, just to mention a few.

To bring to life Acadia's purpose, let us share a testimonial we received from one of our acute psychiatric patients:

"Before going to [Acadia facility] I was in the darkest moments of my life…When I say [Acadia facility] changed my life in ways I never thought possible—I mean that. The staff was incredible. (I would name drop but for their privacy I won't). I was so scared going in, I cried, second guessed myself and doubted I would be treated like an individual. Almost immediately after being admitted I felt almost at home. Sure I was super anxious but the way the staff cares, sees you, and hears you is unmatched…As someone who also was terrified about group therapy (as I am someone who isolates and doesn't talk to many people) the set up was life changing and the people I met who was in there with me I feel I can safely say have made the biggest positive impact on my life…I literally cannot say thank you enough to this staff. I literally feel heartbroken I won't see any of them while I'm not in there, but each one of them has given me the best advice and guidance I could dream of…Thank You and I wish everyone there all the happiness life has to offer because y'all made me realize that I want to live and there's a reason I'm on this earth."

In the achievement of our purpose, we strive to provide treatment that is synonymous with care, compassion and innovation. To our patients, we commit ourselves to providing quality, individualized care at treatment facilities that offer a welcoming, caring environment in which they – and their loved ones – can regain hope. To our employees, we commit ourselves to fostering a culture that encourages them both personally and professionally, supporting them as they reach their career goals and achieve to their greatest potential in support of our mission to transform lives. Throughout, Acadia embraces a spirit of innovation and inclusion in everything that we do, including as an opportunity to learn from what others experience and improve how we work together and deliver care.

Our more than 23,000 clinicians, caregivers, and other employees often choose to work for Acadia in part because of deep personal experiences with the damage untreated behavioral health issues can wreak on lives and communities. For example, as one of our frontline leaders in rural northern Georgia, shared, *"I struggled with addiction and mental health for many years. After finally getting out, helping others on their recovery journey as they navigated the darkness of addiction quickly became a passion for me. Being a light for them inspired me to become an overnight tech in the industry and move up the ranks to counselor, operations director, clinical director and now CEO."* Another Acadia employee, this time in Memphis, Tennessee, recently shared, *"The WHY for me joining Acadia…is my brother-in-law, who tragically lost his battle with mental health. Our lives were forever changed as we said goodbye to [him]."*

To provide one more example of the mission-driven nature of Acadia and our teammates, let me share this testament from one of our Pennsylvania employees who works in our opioid treatment program service line, which is most pertinent to your letter. She recently shared the following: *"As someone deeply familiar with the challenges of navigating mental health and addiction within my own family, I bring a unique perspective and personal investment to my role in behavioral health. The loss of my sister to addiction after years of suffering from undiagnosed trauma, coupled with my son's daily battle with autism and bipolar disorder, has ignited within me a profound sense of purpose. My experiences have fueled my commitment to advocating for those facing similar struggles, driving me to work tirelessly to provide support, resources, and compassionate care to individuals and families affected by behavioral health issues…I am grateful to work for a company that enables me to fulfill my purpose through our work."*

We provide treatment across four major service lines: acute psychiatric hospitals, specialty residential for substance abuse and mental health issues, residential treatment centers focused on child and adolescent populations, and Comprehensive Treatment Centers for opioid use disorder (hereafter referred to as opioid treatment programs, or OTPs, as they are known more broadly in the industry). We also offer partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs). We offer this uniquely comprehensive continuum of care in order to meet patients wherever they are in their treatment journey — and then continue to support them in an integrated way as their needs evolve. Relevant to your letter, we are not owned by a private equity entity – we are publicly traded and have been for more than 12 years (NASDAQ: ACHC). In fact, it is worth noting that based on the best data available to us, there appear to be an equal or larger number of non-profit OTPs in the U.S. as compared to private equity backed programs.[1]

In recognition of the overall impact we are having on the communities we serve, Acadia was recently ranked among the top 15 "Most Trustworthy Healthcare Companies in America 2024" by Newsweek.[2] Even more impressive, Acadia was among the top 5 most trustworthy health systems. We believe this trust is founded in part on the mission-driven nature of our work, but also on the tangible quality and outcomes we have achieved for our patients across our service lines. For example, Acadia's acute psychiatric hospital division outperformed key CMS quality benchmarks in 2023, including scoring three-to-five-fold better than the national average performance relative to two of the most important metrics (minimization of seclusion and of restraints).[3] To cite another

[1] Based on SAMHSA data
[2] https://www.newsweek.com/rankings/most-trustworthy-companies-america-2024
[3] CMS Inpatient Psychiatric Facility Quality Measure Data - National

example, in our Specialty service line seven of our facilities were named in America's Best Addiction Treatment Centers by Newsweek.[4]

But as the nation's largest opioid treatment program (OTP) provider, we are particularly proud of the care our 3,000 clinicians deliver to the more than 70,000 OUD patients we treat at our 160 OTPs and 7 mobile vans. Notably, Acadia was awarded scores of 99% or above in each of the 13 measures assessed by the Commission on Accreditation of Rehabilitation Facilities (CARF), the nation's leading OUD accreditation organization (example measures of Health & Safety, Accessibility, Technology, and Performance Improvement).

Additionally, more than 80% of patients under our care achieve abstinence from illicit opioids within six months of treatment initiation, a significant achievement with such a complex and high-need patient population. These outcomes are made possible by our mission-driven clinical culture paired with deep and ongoing investments, including in the areas of clinical excellence (e.g. evidence-based training, enhanced induction, expanded take-home medications), social determinants of health support (e.g. housing, transport, food insecurity, vocational training), and technology (e.g. electronic medical record investment, telehealth expansion, high-precision robotic drug dosing, predictive analytics).

To bring to life the impact of our OUD care, let us share a few testimonials we received from our opioid treatment program patients:

"This program means the world to me. I have gone from staying pretty much alone and to myself for years dealing with issues. Since I've been here I have reconnected with my family and my parents have both told me they have the son back that they thought they had 20 years ago. This place has been a lifesaver."

"When I started coming to [Acadia opioid treatment center]…quite frankly, I wasn't sure if I even wanted to continue to live. Let alone work a program. Why? I'm in my mid 40's and have been using opiates and opiate derived substances since I was 19… Am I fixed? Am I immune to obstacles now that I'm involved in a program? Nope. I've just slowed down enough to be part of some necessary realizations, and some long-time needed action for change. It is nice to feel supported as we expose our difficulties and open for change."

"I ... have used drugs my entire adult life on and off. I have been in and out of treatment center and hospitals and so on. This clinic has saved my life."

Consideration 2: We wholeheartedly agree that greater access to robust medication-assisted treatment, including methadone, is needed – and Acadia has played a leadership role in this effort for many years, including by funding new clinics, mobile vans, and tech-enabled care.

We applaud your highlighting of the gravity of the opioid epidemic in this country. Overdose deaths are at record levels, and as you will appreciate, our 3,000 clinicians witness and battle against this crisis on a daily basis across the country. It is more important than ever before that private, public and regulatory partners work together to find solutions.

[4] America's Best Addiction Treatment Centers 2023

The medication-assisted care model delivered by OTPs is the "gold standard" of care for treating OUD patients. As will be discussed further below, it is the gold standard not due to the provision of methadone or other drugs in isolation – but instead due to the comprehensive, carefully-regulated OTP treatment model, which has been refined based on decades of clinical practice and patient outcomes. There is overwhelming evidence regarding the efficacy of the OTP model when delivered via this integrated, well-regulated approach. In fact, the mortality rate for individuals with OUD is 8.2 times higher for those outside of medication-assisted treatment versus those enrolled.[5] Another study analyzing patient data in Massachusetts found that opioid overdose deaths decreased by 59% for individuals receiving methadone-assisted therapy, including wraparound services, compared to those not receiving medication-assisted treatment.[6]

But approximately 1 in 10 Americans lacks reasonable geographic access to an OTP. Specifically, 12.8% of Americans do not live within 30 miles, straight line, or a 40-minute drive from an OTP.[7]

This coverage gap is shrinking rapidly, in part driven by continued investments by Acadia, which will be discussed further below. According to the US Department of Health and Human Services, there were 1,282 OTPs[8] in the US in 2013, meaning that an estimated 30% of adult Americans lacked convenient access to an OTP. Today, a little more than ten years later, there are 2,066 OTPs, and the resulting percentage of adult Americans without convenient access to an OTP has dropped from about 30% to 12.8%.

But let us be clear — it is critical that we fill the remaining gap. And as we will discuss in more detail later in this letter, there are concrete steps we can be taking, should be taking, and in some cases are already taking to achieve this goal while keeping patients safe.

Consideration 3: But we echo concerns by law enforcement, experienced clinicians, state governments, former government officials, and other community stakeholders regarding the patient safety risks of the legislative proposal mentioned in your letter.

While it is critical that we continue to expand access to gold standard OUD treatment, we believe this must be accomplished without sacrificing patient safety. And we believe the legislative proposal mentioned in your letter would put patients unnecessarily at risk.

Acadia is not alone in this view. On December 4, 2023, six of the nation's largest and most respected law enforcement organizations, including the National Sheriffs' Association, the National Alliance of State Drug Enforcement Agencies, and the National Narcotics Officers' Association, co-wrote a letter to key congressional leaders regarding S 6.44 (the Modernizing Opioid Treatment Act).[9] They, like Acadia, "support the bill's intent." But they expressed "concerns" that "changes proposed by this legislation could contribute to a rise in crimes

[5] D.A. Zania, G. E. Woody / Drug and Alcohol Dependence 52 (1998) 257–260.
[6] Marc R. Larochelle, MD, MPH, Dana Bernson, MPH, Thomas Land, PhD, Thomas J. Stopka, PhD, MHS, Na Wang, MA, Ziming Xuan, ScD, SM, Sarah M. Bagley, MD, MSc, Jane M. Liebschutz, MD, MPH, and Alexander Y. Walley, MD, MSc. (2018). *Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study*. Annals of Internal Medicine: Vol 169, No 3 https://www.acpjournals.org/doi/10.7326/M17-3107.
[7] Research & Planning Consultants analysis
[8] 2019 SAMHSA data
[9] https://mcsheriffs.com/wp-content/uploads/2023/12/Letter-Modernizing-Opioid-Treatment-Access-Act-2023-12-4-23.pdf

associated with the illegal trade of methadone." Moreover, they cited potential "unintended consequences for an individual's recovery plan, risk abuse and relapse." They reinforced that the industry regulations and guardrails that would be undermined by the bill are "necessary to ensure safe and effective treatment."

State governments have expressed even greater concerns over methadone safety, and are actually stepping in to increase oversight of methadone access beyond existing Federal regulations in some cases (e.g. Oklahoma's Hannah McKenzie Act of 2023,[10] West Virginia's proposed Medication Assisted Treatment Program Licensing Act of 2024[11]).

We at Acadia agree with concerns regarding the proposed legislation. Fundamentally, the legislative proposal mentioned in your letter would undermine the two factors that are perhaps most responsible for the OTP model becoming the "gold standard." First, its comprehensiveness, including the combination of medication-assisted treatment with integrated individual therapy, group counseling, and coordination of treatment with other medical and psychological needs. As one of our patients shared with us, *"Today I am still illicit free from drugs…I could not have done it without my counselor Trish. Since day one of being my counselor she has had my back. I always enjoyed our counseling sessions because talking with her felt more like talking with family then an employee somewhere."* Second, the mentioned legislative proposal would undermine the OTP model's built-in patient safety guardrails, including highly structured drug testing, anti-diversion programs, and take-home medication guidelines. As one of our patients shared in a recent testimonial, *"The [staff] are very understanding but they also make sure you are doing what you need to do for your recovery."* As a result of these two factors, we believe that the significant proposed regulatory changes to the successful OTP model would have potentially deadly unintended consequences.

Concerns expressed by law enforcement, Acadia, and other stakeholders regarding undermining the regulatory structure of the OTP model are corroborated by both recent history and extensive academic studies in the U.S. and around the world.

Methadone has two uses in our healthcare system: (1) pain management and (2) addiction treatment. Methadone used for pain management is not subject to the restrictions of methadone used for addiction treatment. In the 2000s, there was a dramatic increase in methadone prescribed for pain by doctors through pharmacies. The results of this were devastating. By the mid-2000s, groundbreaking research was published in the Journal of Pharmacoepidemiology and Drug Safety showing a clear increase in deaths involving methadone and the correlation between those deaths and increased prescribing of methadone for pain distributed via pharmacies.[12] These initial findings resulted in a series of federal studies and reports reviewing the impacts of methadone distribution by pharmacies. The research confirmed that looser prescribing of methadone increases drug overdose deaths. A sampling of those reports and their findings includes:

- A Substance Abuse and Mental Health Services Administration (SAMHSA) report from 2004 found "a correlation between increased pharmacy distribution of methadone

[10] Hannah McKenzie Act signed into law to regulate opioid substitution treatment programs

[11] https://www.wvlegislature.gov/Bill_Text_HTML/2024_SESSIONS/RS/bills/sb295%20intr.pdf

[12] Paulozzi, L. J., Budnitz, D. S., & Xi, Y. (2006). *Increasing deaths from opioid analgesics in the U.S.*. Pharmacoepidemiology and drug safety, 15(9), 618–627. https://doi.org/10.1002/pds.1276.

tablets…and increased problems with methadone, including methadone-associated deaths."[13]

- A National Drug Intelligence Center report from 2007 found "Methadone poisoning deaths increased 390 percent from 1999 through 2004… Most deaths are attributed to the abuse of methadone diverted from hospitals, pharmacies, practitioners, and pain management physicians… The percentage increase in methadone deaths exceeds the percentage increase in "other opioid" (including oxycodone, morphine, hydromorphone, and hydrocodone) deaths during the same period."[14]

- A second SAMHSA report from 2007 found "Methadone-associated deaths continue to rise" as do "all forms of methadone distribution" but "the greatest increases in distribution [are] for the tablet form and going to pharmacies."[15]

- A Government Accountability Office report from 2009 found "methadone's growing use for pain management has made more of the drug available, thus contributing to the rise in methadone associated overdose deaths… DEA data suggest that abuse of methadone diverted from its intended purpose has also contributed to the rise in overdose deaths as the number of methadone drug items seized by law enforcement and analyzed in forensic laboratories increased 262 percent."[16]

- In a 2009 analysis of data from selected states, methadone was implicated in 40 percent of deaths involving one opioid and this was more than twice the deaths attributed to other drugs in its class.[17]

- A third SAMHSA report from 2010 found that "There is substantial agreement that patients are at elevated risk of methadone-associated mortality if they… are given too large induction doses or are not adequately monitored during induction." Additionally, the study noted again that "the data show us that the greatest growth in distribution of methadone involves the tablet form, which is dispensed only through pharmacies."[18]

Recently-published studies of methadone take-home flexibilities provided during the COVID-19 pandemic indicate that the methadone prescribing and distribution risks of the 1990s and 2000s remain relevant today. In March 2020, SAMHSA permitted OTPs to provide up to 28 days of take-home methadone to patients as a means of facilitating access to methadone treatment during the pandemic. Recent studies of this historic shift in how methadone is distributed, from a model where patients receive methadone daily at an OTP to a model where monthly doses are taken home by patients, demonstrate that the regulatory changes were not universally successful.

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[13] Center for Substance Abuse Treatment, *Methadone-Associated Mortality: Report of a National Assessment*, May, 2003. SAMHSA Publication No. 04-3904. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2004.
[14] National Drug Intelligence Center, *Methadone Diversion, Abuse, and Misuse: Deaths Increasing at Alarming Rate* November 16, 2007 Document ID: 2007-Q0317-001.
[15] Center for Substance Abuse Treatment, *Summary Report of the Meeting: Methadone Mortality– A Reassessment* July 20, 2007
[16] U.S. Government Accountability Office, *Methadone Associated Overdose Deaths: Factors Contributing To Increased Deaths And Efforts To Prevent Them* March 2009.
[17] Pew: Prescription Drug Abuse Epidemic: Methadone. August 2014.
[18] Substance Abuse And Mental Health Services Administration *Data Summary: Methadone Mortality: A 2010 Reassessment* July, 2010

While a 2022 study demonstrated that the most stable patients had success in accessing methadone under the pandemic flexibilities, this same study demonstrated a concerning increase in methadone overdoses as well – particularly among minorities. Specifically, there was an increase in methadone-involved overdoses of 105.4 deaths per month, an increase of 26.5%, compared to similar periods prior to the regulatory flexibilities.[19] Some have suggested this was due to increases in the rates of fentanyl overdoses that occurred during the same period, but the study noted that the "methadone-involved overdose deaths" that increased 26.5% were those "without synthetic opioids" like fentanyl and noted that "compared with prior trends Methadone-involved overdose deaths increased above previous trends both with and without co-involvement of synthetic opioids." Of particular note were the impacts for minorities. As the study notes, "the relative percentage increase in methadone-involved overdose deaths, both with and without synthetic opioid co-involvement, was highest among Hispanic and non-Hispanic Black individuals." There was an increase in methadone-involved overdose deaths of 48% among Hispanic individuals and 31% among non-Hispanic Black individuals, while there was also a 16% increase among non-Hispanic White individuals. What makes these findings particularly concerning from a public health perspective is that this increase in "methadone-involved overdose deaths occurred despite a 24% reduction in the number of patients receiving methadone in the U.S. between 2019 and 2020."

A separate 2023 study looking at this same issue found that methadone overdoses increased 48.1% between 2019 (prior to regulatory flexibility) and 2020 (after regulatory flexibility).[20] The study notes that "this increase is consistent with, but also much larger than, the 5.3% elevation in calls involving methadone reported nationally to poison control centers in the year following the March 16, 2020, relaxation of methadone take-home regulations." The study found "a strong correlation" between the "distribution of methadone for OUD and methadone overdoses."

Our nation's experience thus far with regulatory flexibilities has been focused on well-established and stable patients being shifted to lower levels of monitoring. Even for this well-controlled population there have been mixed results. It is therefore important to acknowledge that if regulatory changes, as proposed by your legislation, are extended to more fragile populations, it is likely the mix of risk and reward will shift even further towards risk. The concern regarding this risk from a regulatory loosening of policy is not limited to the U.S.

The European experience on this issue provides additional insights into the risk and potential unintended consequences of this policy change. For example, the Danish model expanded to permit take-home methadone coupled with decreased in-person visits, supervision, and drug testing. These changes had mixed results. The number of heroin overdoses in the country decreased, but the number of methadone overdoses increased. The increase in methadone overdoses, tragically, increased among both those prescribed methadone and not prescribed methadone. And the increase in overdoses was approximate to the decrease in heroin overdoses,

[19] Kleinman, R. A., & Sanches, M. (2023). Methadone-involved overdose deaths in the U.S. before and during the COVID-19 pandemic. Drug and alcohol dependence, 242, 109703. https://doi.org/10.1016/j.drugalcdep.2022.109703

[20] Kaufman, D. E., Kennalley, A. L., McCall, K. L., & Piper, B. J. (2023). Examination of methadone involved overdoses during the COVID-19 pandemic. Forensic science international, 344, 111579. https://doi.org/10.1016/j.forsciint.2023.111579

thereby limiting the benefit of the regulatory changes.[21] Similar patterns of expanded access resulting in mixed outcomes have been identified in Sweden[22] and the United Kingdom.[23,24]

We appreciate the goal of your legislation to provide greater access to methadone. The peer-reviewed research discussed, however, highlights the risk your legislation poses to patient safety. It is that evidence, along with our experience treating these patients and the public concern expressed by law enforcement and others, that animates our concerns. For these reasons, before advancing legislation, we urge all parties to pause and study carefully the effects of the significant recent efforts to expand access, with a specific focus on understanding the root causes behind incremental overdoses, as well as the disproportionate harm suffered by marginalized populations.

Key third party experts are also urging caution and study before making major structural changes to OTP regulation: former Assistant Secretary for Planning and Evaluation under President Obama, Richard Frank, in his comments on SAMHSA's changes to methadone prescribing, stated that the "Government Accountability Office or equally credible evaluator should be tasked with performing an extended evaluation of the impact of the new regulations…This evaluation should examine impact on accessibility of MOUD care, retention in MOUD care, medication diversion, and overdose deaths among individuals prescribed and not prescribed MOUD. The evaluation should also include a process study of a representative sample of care providers to determine how they are determining which patients are subject to what level of monitoring."

Consideration 4. Further, due to multiple practical limitations, it is increasingly clear that the proposed legislation would have a disappointingly small impact on access to care, particularly in rural areas.

The legislative proposal in your letter would expand methadone prescription power to a larger set of providers beyond those providers associated with opioid treatment programs. At the surface level, this would appear to significantly increase access to care, and supporters of the bill explicitly state their goal of improving access in rural areas – addressing the 12.8% of Americans mentioned earlier who currently lack reasonable geographic access to an OTP.

But for three main practical reasons, Acadia and industry groups believe the practical impact of the proposed legislation on access to care for OUD patients would be minimal, particularly in rural areas.

Firstly, because analysis suggests that the new prescribers identified in the proposed bill – which are highly specialized physicians – appear to live predominately in urban areas,[25] just as is true for

[21] Christian Tjagvad, Svetlana Skurtveit, Kristian Linnet, Ljubica Vukelic Andersen, Dorte J. Christoffersen, and Thomas Clausen. "Methadone-Related Overdose Deaths in a Liberal Opioid Maintenance Treatment Programme." European Addiction Research 22, no. 5 (2016):249-258. doi:10.1159/000446429

[22] Anna Fugelstad. "What Lessons from Sweden's Experience Could be Applied in the U.S. in Response to the Addiction and Overdose Crisis. Addiction 117, no. 5 (2022): 1189-1191. https://doi.org/10.1111/add.15847

[23] John Strang, Wayne Hall, Matt Hickman, and Sheila M. Bird. "Impact of Supervision of Methadone Consumption on Deaths Related to Methadone Overdose (1993-2008): Analyses Using OD4 Index in England and Scotland." BMJ 341, no. 4851 (2010). https://doi.org/10.1136/bmj.c4851

[24] D Aldabergenov, L Reynolds, J Scott, MJ Kelleher, J Strang, CS Copeland, and NJ Kalk. "Methadone and Buprenorphine-Related Deaths Among People Prescribed and Not Prescribed Opioid Agonist Therapy During the COVID-19 Pandemic in England." International Journal of Drug Policy 110, no. 103877 (2022). https://doi.org/10.1016/j.drugpo.2022.103877

[25] Research & Planning Consultants analysis

specialized physicians more broadly.[26] In fact, these proposed new prescribers appear to be more urbanized in their geographic footprint, on average, relative to current opioid treatment programs rather than less urbanized. At a more generalized level, this is corroborated by the fact that an estimated 65% of nonmetropolitan counties do not have a single practicing psychiatrist.[27]

Secondly, analysis suggests that most of the proposed new physician prescribers do not report serving Medicaid beneficiaries, despite the fact that most individuals with OUD[28] and the vast majority of OUD patients seeking care at OTPs rely on Medicaid for access to healthcare. This statement is based on the work by Research & Planning Consultants (RPC), an analytics group. To determine Medicaid eligibility, RPC filtered proposed new prescribers from the CMS NPI file who listed Medicaid in the "Other Provider Identifier" field, which can be used to match NPI records to insurers' records. Among the addiction medicine physicians that were able to be identified, only 38% met these parameters.

Finally, even within the small share of proposed new prescribers who both live in rural areas and accept Medicaid, it is unclear what percentage are taking new patients, and if so, how long their waiting lists are. The national average wait time to see a psychiatrist is 67 days.[29] For the high-complexity, time-sensitive needs of OUD patients, this is an eternity. In contrast, there is a zero-day wait time (same day service with no wait lists) at every one of Acadia's opioid treatment programs across the country.

Consideration 5: We believe that concrete actions can and should be taken to improve OUD treatment access without putting patients at risk, including via alternative policy approaches. We are playing a key leadership role in advancing many of these strategies, but we also need your help.

Despite our concerns with the legislative proposal mentioned in your letter, we do believe there are a range of important actions that can and should be taken to improve access to gold standard OUD care and address the broader opioid crisis. We think of these actions as falling into three main categories: continued footprint expansion of opioid treatment programs into remaining underserved areas, continued care model innovation, and policy changes.

Continued footprint expansion of OTPs into remaining underserved areas: As discussed earlier, the percentage of Americans lacking reasonable geographic access to an OTP has dropped from approximately 30% in 2013 to 12.8% in 2023. This is driven by the addition of approximately 75-80 new OTP clinics per year during this time period, and Acadia has played a key role in this expansion, adding dozens of new clinics in recent years.

[26] Cyr ME, Etchin AG, Guthrie BJ, Benneyan JC. Access to specialty healthcare in urban versus rural U.S populations: a systematic literature review. BMC Health Serv Res. 2019 Dec 18;19(1):974. doi: 10.1186/s12913-019-4815-5. PMID: 31852493; PMCID: PMC6921587.

[27] Morales DA, Barksdale CL, Beckel-Mitchener AC. A call to action to address rural mental health disparities. J Clin Transl Sci. 2020 May 4;4(5):463-467. doi: 10.1017/cts.2020.42. PMID: 33244437; PMCID: PMC7681156.

[28] https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/

[29] Sun CF, Correll CU, Trestman RL, Lin Y, Xie H, Hankey MS, Uymatiao RP, Patel RT, Metsutnan VL, McDaid EC, Saha A, Kuo C, Lewis P, Bhatt SH, Lipphard LE, Kablinger AS. Low availability, long wait times, and high geographic disparity of psychiatric outpatient care in the U.S. Gen Hosp Psychiatry. 2023 Sep-Oct; 84:12-17. doi: 10.1016/j.genhosppsych.2023.05.012. Epub 2023 May 25. PMID: 37290263.

To bridge the remaining 12.8% geographic access gap, OTP providers should continue to devote resources to building new clinics – and we are. In 2024 alone, for example, Acadia is planning to add a minimum of 14 new OTP clinics (a more than two-fold acceleration relative to 2023). In total, Acadia alone plans to dedicate hundreds of millions of dollars of capital towards meeting the nation's opioid treatment needs in the coming years. And when selecting sites for new clinics, Acadia and other providers intentionally target "whitespace" areas where geographic coverage is currently lacking – because this is where the need lies.

Continued care model innovation: In addition to expanding our footprint of traditional OTP clinics, Acadia and other OTP providers are also working to improve treatment access and equity through innovation, with particular focus on improving access in rural areas. Acadia is doing this in multiple ways. A few key examples:

- **Mobile vans:** With the goal of expanding access in rural and underserved areas, Acadia was the first player in the industry to launch opioid treatment program mobile vans. Mobile units operate under the license of an existing OTP and travel daily to one or more locations to treat patients. At present, Acadia operates 7 mobile units with an additional eight in development – the largest fleet in the country – and has plans to expand in multiple states this year.
- **Satellite dispensing sites:** Medication dosing units, or "med units" are locations that provide medication to patients at a satellite location operating under the license of an existing OTP. Development of med units allows Acadia's OTPs to provide critical access to treatment in geographies where patients would otherwise need to travel long distances for care. Acadia has plans to open multiple med units this year, including with partner organizations that treat the most underserved patients such as medical respites and community health centers.
- **Telehealth:** Acadia seeks to make all elements of our OTP care model more accessible and convenient to patients. This includes provision of telehealth services for patients' individual and group counseling sessions. Further, Acadia partners with a third-party digital health technology company to remote-monitor patient medication administration, which improves patient retention in treatment and promotes safer administration of take-home medication doses.
- **Speedy, streamlined patient experience:** When compared to other facets of the behavioral health provider landscape across the country, Acadia's patient service performance is unparalleled. As previously mentioned, patients wait an average of 67 days to see a psychiatrist.[30] Average wait times at Acadia's OTPs are less than 5 minutes and patient admissions/intake is done same-day.
- **Addressing social determinants of health (SDOH), including via Uber partnership:** As previously mentioned, the comprehensive opioid treatment program model Acadia delivers includes helping connect patients with social determinants of health resources and support (e.g. housing, transport, food insecurity, vocational training). An example of this work is Acadia's recent partnership with Uber Health focused on providing same-day transportation to our clinics for patients with transportation barriers.[31]

[30] Sun CF, Correll CU, Trestman RL, Lin Y, Xie H, Hankey MS, Uymatiao RP, Patel RT, Metsutnan VL, McDaid EC, Saha A, Kuo C, Lewis P, Bhatt SH, Lipphard LE, Kablinger AS. Low availability, long wait times, and high geographic disparity of psychiatric outpatient care in the U.S. Gen Hosp Psychiatry. 2023 Sep-Oct; 84:12-17. doi: 10.1016/j.genhosppsych.2023.05.012. Epub 2023 May 25. PMID: 37290263.
[31] https://www.nasdaq.com/articles/acadia-achc-and-uber-health-to-enhance-patient-access

Additionally, Acadia provides specialized clinical programs for vulnerable groups, including pregnant women, individuals involved in the criminal justice system, and otherwise underserved groups. Our treatment approach for pregnant and parenting women with OUD involves a combination of medical, psychological, and social interventions, with a focus on the well-being of both the mother and the developing fetus and young children. We also provide medication delivery to multiple jail and prison settings, and partner with multiple organization to ensure seamless transitions to community-based OTP care for individuals in need upon release, which significantly reduces risk of overdose post-incarceration.

To help accelerate and expand the impact of our innovation work in the opioid treatment space, we also collaborate closely with external partners, including the University of North Carolina, to develop and implement innovative community-based strategies to improve access to care and mitigate the devastating effects of the opioid epidemic.

Policy changes: Finally, we believe there are ongoing opportunities for positive policy change in the opioid treatment space that would improve access to care while keeping patients safe. For example, Acadia, along with the OTP community, strongly supports recent federal actions to expand access to care via telehealth services and other flexibilities offered through regulatory revisions.

We also encourage you and your colleagues in the House and Senate to consider additional policy changes that would make it easier to expand OTP services. Some ideas include incentivizing communities to change their restrictive zoning policies that often prohibit or slow the establishment of new OTPs, incentivizing states to remove excessive restrictions on expanding healthcare capacity (e.g., certificate-of-need laws), providing resources to patients who have transportation challenges, enforcement of mental health and addiction parity laws so patients can have adequate insurance coverage, and remove onerous and restrictive prior authorization policies.

Conclusion: Progress in reducing methadone overdose deaths in the U.S. has been one of the true bright spots in the national effort to turn the tide on the opioid epidemic. Between 1999 and 2004, the percentage increase in methadone overdose deaths exceeded the percentage increase in "other opioid" (including oxycodone, morphine, hydromorphone, and hydrocodone) deaths. This tragic trend in methadone overdoses peaked in 2007. Through a series of local, state, and federal efforts, we experienced declining methadone overdose deaths between 2007 and 2019. That 12-year streak of declining methadone overdose deaths ended in 2020. Today, methadone still accounts for up to 10% of opioid overdose deaths in some states.[32] But given all the progress that has been made, we are sure you appreciate the concern stakeholders have about the potential unintended consequence of your legislation and the risks of putting in jeopardy more than a decade of progress on methadone overdose deaths.

Hence, we wholeheartedly support the need to increase access to gold standard methadone-assisted treatment – but we equally believe that patient safety must remain paramount, and that the legislative proposal mentioned in your letter would unintentionally put patients at risk.

[32] CDC/SAMHSA, 2021

Instead, we recommend several other concrete actions that can be taken to improve treatment access safely and effectively, including continuing to accelerate geographic expansion of OTPs into underserved areas, continuing to support tech-enabled access-to-care innovation in the opioid space, and continuing to advance policies that support access without putting patients at risk, such as preserving telehealth provisions and streamlining the process of standing up new clinics.

We thank you for your letter and welcome the opportunity to partner with you towards mutually agreeable solutions that will ensure all Americans have access to quality care, including OTP services.

Sincerely,

Christopher H. Hunter
Chief Executive Officer
Acadia Healthcare