

114TH CONGRESS
1ST SESSION

S. 1455

To provide access to medication-assisted therapy, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 22, 2015

Mr. MARKEY (for himself, Mr. PAUL, Mrs. FEINSTEIN, Mr. DURBIN, Ms. HIRONO, Mr. BROWN, and Ms. BALDWIN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To provide access to medication-assisted therapy, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Recovery Enhancement
5 for Addiction Treatment Act” or the “TREAT Act”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

8 (1) Overdoses from opioids have increased dra-
9 matically in the United States.

1 (2) Deaths from drug overdose, largely from
2 prescription pain relievers, have tripled among men
3 and increased five-fold among women over the past
4 decade.

5 (3) Nationwide, drug overdoses now claim more
6 lives than car accidents.

7 (4) Opioid addiction is a chronic disease that,
8 untreated, places a large burden on the healthcare
9 system. Roughly 475,000 emergency room visits
10 each year are attributable to the misuse and abuse
11 of opioid pain medication.

12 (5) Effective medication-assisted treatment for
13 opioid addiction, in combination with counseling and
14 behavioral therapies, can decrease overdose deaths,
15 be cost-effective, reduce transmissions of HIV and
16 viral hepatitis, and reduce other social harms such
17 as criminal activity.

18 (6) Effective medication-assisted treatment pro-
19 grams for opioid addiction should include multiple
20 components, including medications, cognitive and be-
21 havioral supports and interventions, and drug test-
22 ing.

23 (7) Effective medication-assisted treatment pro-
24 grams for opioid addiction may use a team of staff

1 members, in addition to a prescribing provider, to
2 deliver comprehensive care.

3 (8) Access to medication-assisted treatments,
4 including office-based buprenorphine opioid treat-
5 ment, remains limited in part due to current prac-
6 tice regulations and an insufficient number of pro-
7 viders.

8 (9) More than 10 years of experience in the
9 United States with office-based buprenorphine opioid
10 treatment has informed best practices for delivering
11 successful, high quality care.

12 **SEC. 3. EXPANSION OF PATIENT LIMITS UNDER WAIVER.**

13 Section 303(g)(2)(B) of the Controlled Substances
14 Act (21 U.S.C. 823(g)(2)(B)) is amended—

15 (1) in clause (i), by striking “physician” and in-
16 serting “practitioner”;

17 (2) in clause (iii)—

18 (A) by striking “30” and inserting “100”;

19 and

20 (B) by striking “, unless, not sooner” and
21 all that follows through the end and inserting a
22 period; and

23 (3) by inserting at the end the following new
24 clause:

1 “(iv) Not earlier than 1 year after the date
2 on which a qualifying practitioner obtained an
3 initial waiver pursuant to clause (iii), the quali-
4 fying practitioner may submit a second notifica-
5 tion to the Secretary of the need and intent of
6 the qualifying practitioner to treat an unlimited
7 number of patients, if the qualifying practi-
8 tioner—

9 “(I)(aa) satisfies the requirements of
10 item (aa), (bb), (cc), or (dd) of subpara-
11 graph (G)(ii)(I); and

12 “(bb) agrees to fully participate in the
13 Prescription Drug Monitoring Program of
14 the State in which the qualifying practi-
15 tioner is licensed, pursuant to applicable
16 State guidelines; or

17 “(II)(aa) satisfies the requirements of
18 item (ee), (ff), or (gg) of subparagraph
19 (G)(ii)(I);

20 “(bb) agrees to fully participate in the
21 Prescription Drug Monitoring Program of
22 the State in which the qualifying practi-
23 tioner is licensed, pursuant to applicable
24 State guidelines;

1 “(cc) practices in a qualified practice
2 setting; and

3 “(dd) has completed not less than 24
4 hours of training (through classroom situa-
5 tions, seminars at professional society
6 meetings, electronic communications, or
7 otherwise) with respect to the treatment
8 and management of opiate-dependent pa-
9 tients for substance use disorders provided
10 by the American Society of Addiction Med-
11 icine, the American Academy of Addiction
12 Psychiatry, the American Medical Associa-
13 tion, the American Osteopathic Associa-
14 tion, the American Psychiatric Association,
15 or any other organization that the Sec-
16 retary determines is appropriate for pur-
17 poses of this subclause.”.

18 **SEC. 4. DEFINITIONS.**

19 Section 303(g)(2)(G) of the Controlled Substances
20 Act (21 U.S.C. 823(g)(2)(G)) is amended—

21 (1) by striking clause (ii) and inserting the fol-
22 lowing:

23 “(ii) The term ‘qualifying practitioner’
24 means the following:

1 “(I) A physician who is licensed under
2 State law and who meets 1 or more of the
3 following conditions:

4 “(aa) The physician holds a
5 board certification in addiction psychi-
6 atry from the American Board of
7 Medical Specialties.

8 “(bb) The physician holds an ad-
9 diction certification from the Amer-
10 ican Society of Addiction Medicine.

11 “(cc) The physician holds a
12 board certification in addiction medi-
13 cine from the American Osteopathic
14 Association.

15 “(dd) The physician holds a
16 board certification from the American
17 Board of Addiction Medicine.

18 “(ee) The physician has com-
19 pleted not less than 8 hours of train-
20 ing (through classroom situations,
21 seminars at professional society meet-
22 ings, electronic communications, or
23 otherwise) with respect to the treat-
24 ment and management of opiate-de-
25 pendent patients for substance use

1 disorders provided by the American
2 Society of Addiction Medicine, the
3 American Academy of Addiction Psy-
4 chiatry, the American Medical Asso-
5 ciation, the American Osteopathic As-
6 sociation, the American Psychiatric
7 Association, or any other organization
8 that the Secretary determines is ap-
9 propriate for purposes of this sub-
10 clause.

11 “(ff) The physician has partici-
12 pated as an investigator in 1 or more
13 clinical trials leading to the approval
14 of a narcotic drug in schedule III, IV,
15 or V for maintenance or detoxification
16 treatment, as demonstrated by a
17 statement submitted to the Secretary
18 by this sponsor of such approved
19 drug.

20 “(gg) The physician has such
21 other training or experience as the
22 Secretary determines will demonstrate
23 the ability of the physician to treat
24 and manage opiate-dependent pa-
25 tients.

1 “(II) A nurse practitioner or physi-
2 cian assistant who is licensed under State
3 law and meets all of the following condi-
4 tions:

5 “(aa) The nurse practitioner or
6 physician assistant is licensed under
7 State law to prescribe schedule III,
8 IV, or V medications for pain.

9 “(bb) The nurse practitioner or
10 physician assistant satisfies 1 or more
11 of the following:

12 “(AA) Has completed not
13 fewer than 24 hours of training
14 (through classroom situations,
15 seminars at professional society
16 meetings, electronic communica-
17 tions, or otherwise) with respect
18 to the treatment and manage-
19 ment of opiate-dependent pa-
20 tients for substance use disorders
21 provided by the American Society
22 of Addiction Medicine, the Amer-
23 ican Academy of Addiction Psy-
24 chiatry, the American Medical
25 Association, the American Osteo-

1 pathic Association, the American
2 Psychiatric Association, or any
3 other organization that the Sec-
4 retary determines is appropriate
5 for purposes of this subclause.

6 “(BB) Has such other train-
7 ing or experience as the Sec-
8 retary determines will dem-
9 onstrate the ability of the nurse
10 practitioner or physician assist-
11 ant to treat and manage opiate-
12 dependent patients.

13 “(cc) The nurse practitioner or
14 physician assistant practices under
15 the supervision of a licensed physician
16 who holds an active waiver to pre-
17 scribe schedule III, IV, or V narcotic
18 medications for opioid addiction ther-
19 apy, and—

20 “(AA) the supervising physi-
21 cian satisfies the conditions of
22 item (aa), (bb), (cc), or (dd) of
23 subclause (I); or

24 “(BB) both the supervising
25 physician and the nurse practi-

1 tioner or physician assistant
2 practice in a qualified practice
3 setting.

4 “(III) A nurse practitioner who is li-
5 censed under State law and meets all of
6 the following conditions:

7 “(aa) The nurse practitioner is li-
8 censed under State law to prescribe
9 schedule III, IV, or V medications for
10 pain.

11 “(bb) The nurse practitioner has
12 training or experience that the Sec-
13 retary determines demonstrates spe-
14 cialization in the ability to treat opi-
15 ate-dependent patients, such as a cer-
16 tification in addiction specialty accred-
17 ited by the American Board of Nurs-
18 ing Specialties or the National Com-
19 mission for Certifying Agencies, or a
20 certification in addiction nursing as a
21 Certified Addiction Registered
22 Nurse—Advanced Practice.

23 “(cc) In accordance with State
24 law, the nurse practitioner prescribes
25 opioid addiction therapy in collabora-

1 tion with a physician who holds an ac-
2 tive waiver to prescribe schedule III,
3 IV, or V narcotic medications for
4 opioid addiction therapy.

5 “(dd) The nurse practitioner
6 practices in a qualified practice set-
7 ting.”; and

8 (2) by adding at the end the following:

9 “(iii) The term ‘qualified practice setting’
10 means 1 or more of the following treatment set-
11 tings:

12 “(I) A National Committee for Qual-
13 ity Assurance-recognized Patient-Centered
14 Medical Home or Patient-Centered Spe-
15 cialty Practice.

16 “(II) A Centers for Medicaid & Medi-
17 care Services-recognized Accountable Care
18 Organization.

19 “(III) A clinical facility administered
20 by the Department of Veterans Affairs,
21 Department of Defense, or Indian Health
22 Service.

23 “(IV) A Behavioral Health Home ac-
24 credited by the Joint Commission.

1 “(V) A Federally-qualified health cen-
2 ter (as defined in section 1905(l)(2)(B) of
3 the Social Security Act (42 U.S.C.
4 1396d(l)(2)(B))) or a Federally-qualified
5 health center look-alike.

6 “(VI) A Substance Abuse and Mental
7 Health Services-certified Opioid Treatment
8 Program.

9 “(VII) A clinical program of a State
10 or Federal jail, prison, or other facility
11 where individuals are incarcerated.

12 “(VIII) A clinic that demonstrates
13 compliance with the Model Policy on
14 DATA 2000 and Treatment of Opioid Ad-
15 diction in the Medical Office issued by the
16 Federation of State Medical Boards.

17 “(IX) A treatment setting that is part
18 of an Accreditation Council for Graduate
19 Medical Education, American Association
20 of Colleges of Osteopathic Medicine, or
21 American Osteopathic Association-accred-
22 ited residency or fellowship training pro-
23 gram.

24 “(X) Any other practice setting ap-
25 proved by a State regulatory board or

1 State Medicaid Plan to provide addiction
2 treatment services.

3 “(XI) Any other practice setting ap-
4 proved by the Secretary.”.

5 **SEC. 5. GAO EVALUATION.**

6 Two years after the date on which the first notifica-
7 tion under clause (iv) of section 303(g)(2)(B) of the Con-
8 trolled Substances Act (21 U.S.C. 823(g)(2)(B)), as added
9 by this Act, is received by the Secretary of Health and
10 Human Services, the Comptroller General of the United
11 States shall initiate an evaluation of the effectiveness of
12 the amendments made by this Act, which shall include an
13 evaluation of—

14 (1) any changes in the availability and use of
15 medication-assisted treatment for opioid addiction;

16 (2) the quality of medication-assisted treatment
17 programs;

18 (3) the integration of medication-assisted treat-
19 ment with routine healthcare services;

20 (4) diversion of opioid addiction treatment
21 medication;

22 (5) changes in State or local policies and legis-
23 lation relating to opioid addiction treatment;

24 (6) the use of nurse practitioners and physician
25 assistants who prescribe opioid addiction medication;

1 (7) the use of Prescription Drug Monitoring
2 Programs by waived practitioners to maximize safety
3 of patient care and prevent diversion of opioid addic-
4 tion medication;

5 (8) the findings of Drug Enforcement Adminis-
6 tration inspections of waived practitioners, including
7 the frequency with which the Drug Enforcement Ad-
8 ministration finds no documentation of access to be-
9 havioral health services; and

10 (9) the effectiveness of cross-agency collabora-
11 tion between Department of Health and Human
12 Services and the Drug Enforcement Administration
13 for expanding effective opioid addiction treatment.

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