

113TH CONGRESS
2D SESSION

S. 2645

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

IN THE SENATE OF THE UNITED STATES

JULY 23, 2014

Mr. MARKEY (for himself, Mrs. FEINSTEIN, Mr. ROCKEFELLER, Mr. BROWN, Ms. HIRONO, and Mr. DURBIN) 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 can decrease overdose deaths, be
14 cost-effective, reduce transmissions of HIV and viral
15 hepatitis, and reduce other social harms such as
16 criminal activity.

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

22 (7) Effective medication-assisted treatment pro-
23 grams for opioid addiction may use a team of staff
24 members, in addition to a prescribing provider, to
25 deliver comprehensive care.

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

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

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

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

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

15 (2) in clause (iii)—

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

17 and

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

21 (3) by inserting at the end the following new
22 clause:

23 “(iv) Not earlier than 1 year after the date
24 on which a qualifying practitioner obtained an
25 initial waiver pursuant to clause (iii), the quali-

1 fying practitioner may submit a second notifica-
2 tion to the Secretary of the need and intent of
3 the qualifying practitioner to treat an unlimited
4 number of patients, if the qualifying practi-
5 tioner—

6 “(I)(aa) satisfies the requirements of
7 item (aa), (bb), (cc), or (dd) of subpara-
8 graph (G)(ii)(I); and

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

14 “(II)(aa) satisfies the requirements of
15 item (ee), (ff), or (gg) of subparagraph
16 (G)(ii)(I);

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

22 “(cc) practices in a qualified practice
23 setting; and

24 “(dd) has completed not less than 24
25 hours of training (through classroom situa-

1 tions, seminars at professional society
2 meetings, electronic communications, or
3 otherwise) with respect to the treatment
4 and management of opiate-dependent pa-
5 tients for substance use disorders provided
6 by the American Society of Addiction Med-
7 icine, the American Academy of Addiction
8 Psychiatry, the American Medical Associa-
9 tion, the American Osteopathic Associa-
10 tion, the American Psychiatric Association,
11 or any other organization that the Sec-
12 retary determines is appropriate for pur-
13 poses of this subclause.”.

14 **SEC. 4. DEFINITIONS.**

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

17 (1) by striking clause (ii) and inserting the fol-
18 lowing:

19 “(ii) The term ‘qualifying practitioner’
20 means the following:

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

24 “(aa) The physician holds a
25 board certification in addiction psychi-

1 atry from the American Board of
2 Medical Specialties.

3 “(bb) The physician holds an ad-
4 diction certification from the Amer-
5 ican Society of Addiction Medicine.

6 “(cc) The physician holds a
7 board certification in addiction medi-
8 cine from the American Osteopathic
9 Association.

10 “(dd) The physician holds a
11 board certification from the American
12 Board of Addiction Medicine.

13 “(ee) The physician has com-
14 pleted not less than 8 hours of train-
15 ing (through classroom situations,
16 seminar at professional society meet-
17 ings, electronic communications, or
18 otherwise) with respect to the treat-
19 ment and management of opiate-de-
20 pendent patients for substance use
21 disorders provided by the American
22 Society of Addiction Medicine, the
23 American Academy of Addiction Psy-
24 chiatry, the American Medical Asso-
25 ciation, the American Osteopathic As-

1 society, the American Psychiatric
2 Association, or any other organization
3 that the Secretary determines is ap-
4 propriate for purposes of this sub-
5 clause.

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

15 “(gg) The physician has such
16 other training or experience as the
17 Secretary determines will demonstrate
18 the ability of the physician to treat
19 and manage opiate-dependent pa-
20 tients.

21 “(II) A nurse practitioner or physi-
22 cian assistant who is licensed under State
23 law and meets all of the following condi-
24 tions:

1 “(aa) The nurse practitioner or
2 physician assistant is licensed under
3 State law to prescribe schedule III,
4 IV, or V medications for pain.

5 “(bb) The nurse practitioner or
6 physician assistant satisfies 1 or more
7 of the following:

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

1 retary determines is appropriate
2 for purposes of this subclause.

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

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

17 “(AA) the supervising physi-
18 cian satisfies the conditions of
19 item (aa), (bb), (cc), or (dd) of
20 subclause (I); or

21 “(BB) both the supervising
22 physician and the nurse practi-
23 tioner or physician assistant
24 practice in a qualified practice
25 setting.

1 “(III) A nurse practitioner who is li-
2 censed under State law and meets all of
3 the following conditions:

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

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

20 “(cc) In accordance with State
21 law, the nurse practitioner prescribes
22 opioid addiction therapy in collabora-
23 tion with a physician who holds an ac-
24 tive waiver to prescribe schedule III,

1 IV, or V narcotic medications for
2 opioid addiction therapy.

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

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

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

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

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

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

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

23 “(V) A Federally-qualified health cen-
24 ter (as defined in section 1905(l)(2)(B) of
25 the Social Security Act (42 U.S.C.

1 1396d(1)(2)(B))) or a Federally-qualified
2 health center look-alike.

3 “(VI) A Substance Abuse and Mental
4 Health Services-certified Opioid Treatment
5 Program.

6 “(VII) A clinical program of a State
7 or Federal jail, prison, or other facility
8 where individuals are incarcerated.

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

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

21 “(X) Any other practice setting ap-
22 proved by a State regulatory board or
23 State Medicaid Plan to provide addiction
24 treatment services.

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

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

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

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

14 (2) the quality of medication-assisted treatment
15 programs;

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

18 (4) diversion of opioid addiction treatment
19 medication;

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

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

24 (7) the use of Prescription Drug Monitoring
25 Programs by waived practitioners to maximize safety

1 of patient care and prevent diversion of opioid addic-
2 tion medication;

3 (8) the findings of Drug Enforcement Agency
4 inspections of waived practitioners, including the fre-
5 quency with which the Drug Enforcement Agency
6 finds no documentation of access to behavioral
7 health services; and

8 (9) the effectiveness of cross-agency collabora-
9 tion between Department of Health and Human
10 Services and the Drug Enforcement Agency for ex-
11 panding effective opioid addiction treatment.

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