November 1, 2021

Chairman Ron Wyden
Senate Finance Committee
221 Dirksen Senate Office Bldg.
Washington, D.C., 20510

Ranking Member Michael Crapo
Senate Finance Committee
239 Dirksen Senate Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

Orexo is pleased to respond to the Finance Committee's request for information on policy solutions that improve access to services for mental and behavioral health, including treatment for substance use disorders (SUDs).

Orexo is a specialty pharmaceutical company focused on the research, development, and commercialization of patient-adapted formulations to address unmet needs. Our mission is grounded in the belief that the needs of patients, providers, and payers can be aligned to improve outcomes and enhance access without increasing costs. Orexo's Zubsolv® sublingual tablets are an advanced formulation of buprenorphine and naloxone indicated for the treatment of opioid dependence as part of a comprehensive treatment plan. We offer Zubsolv® in a broad range of dosages to facilitate patient needs through induction, stabilization, maintenance and tapering (as appropriate) for individuals seeking recovery from opioid use disorder (OUD).

Another critical part of our commitment to patients has been our emphasis on the counseling or "assisted" aspect of MAT. After several years in working with clinicians and patients to understand the barriers to counseling, Orexo has made a commitment in digital therapies to address the unmet medical needs we see in addiction and mental health. Our pharmaceutical and digital therapeutics (DTx) products primarily focus on addiction in all phases, from stabilization to maintenance, and on evidence-based cognitive behavioral therapy for depression.

Increasing Integration, Coordination, and Access to Care

What are the best practices for integrating behavioral health with primary care? What federal payment policies would best support care integration?

Access to Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

According to provisional data released by the Centers for Disease Control & Prevention (CDC), more than 93,000 Americans died of drug overdose in 2020, eclipsing the toll from any year since the

epidemic began in the 1990s.[1] Similarly, the incidence rate for suicide among Black Americans and people of color has increased markedly since the start of the COVID-19 pandemic and the total nationwide percentage of hospital emergency department visits linked to behavioral health crises has also escalated. Dr. Joshua Gordon, Director of the National Institute of Mental Health recently discussed the urgent need for increased mental health and substance use disorder (SUD) capacity, noting:

> [t]he mental health impacts of COVID-19 continue. From all that we know, it is clear these impacts will outlive the pandemic itself. Therefore, it is crucial that we work together to apply evidence-based strategies to support the mental health needs of all Americans and to make these strategies broadly available, especially in vulnerable communities.[2]

HHS' recent guidance announcing exemptions from certain DATA 2000 waiver requirements (specialized training in MAT, coordination of psychosocial and behavioral therapy support) noted that "practitioners practicing under this exemption are encouraged to provide access to psychosocial services, such as counseling, or other ancillary services, or refer as appropriate to licensed behavioral health practitioners in their communities."[3] Orexo supports initiatives that expand access to the medications used within office-based MAT, including the DATA 2000 exemptions announced in the HHS guidance. Reducing both real and perceived barriers to clinician willingness to treat OUD patients with evidence-based MAT is critical to our nation's ability to address the opioid epidemic, and the HHS guidance went as far toward removing the DATA 2000 barriers as possible. Unfortunately, even the relatively small paperwork burden of securing a DATA 2000 waiver creates a clinician requirement beyond what is in place for prescribers of all other treatments, including the opioids at the heart of the epidemic. It places an additional layer of inquiry and scrutiny over each patient, provider, and prescriber both at the pharmacy level and in the form of heightened payer scrutiny.

Federal and state lawmakers, medical professionals, and health policy leaders have stressed a sense of urgency with respect to ensuring that fewer families lose a loved one to overdose, and that every individual struggling with addiction has a meaningful opportunity for sustained recovery. Unfortunately, we continue to struggle with the reality that there are too few providers willing and able to treat OUD patients with MAT. Clinicians prescribing MAT are unable to fully address treatment needs in their communities due to DATA 2000 waiver limits as well as the sheer time required to navigate payer prior authorization and documentation requirements.

- Clinicians willing to prescribe MAT are subject to patient limits – 30 patients for clinicians that have not undergone specific training and 275 patients for those that do. There are no other treatments for which clinicians are limited to an absolute patient number; physicians can prescribe opiates to an unlimited number of patients but cannot treat all individuals seeking care for OUD

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[1] Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)

[2] NIMH » One Year In: COVID-19 and Mental Health (nih.gov).

[3] Federal Register :: Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder

- Prior authorization requirements can include verification of clinician DATA 2000 status and patient capacity, medical documentation of patient need for MAT, and documentation of the patient's need for a specific MAT product and/or dosage. Although it is understood that OUD recovery requires a long-term treatment plan, clinicians may have to renew prior authorization every couple of months and/or justify patient needs for continuing doses of MAT.

In addition, access to OUD treatment medications is increasingly constrained. Patients report difficulties filling prescriptions for buprenorphine, and pharmacists have reported problems ordering buprenorphine-based products for MAT. These issues signal that there is a barrier beyond provider capacity constraints that is likely due to pharmacy- and distributor-level efforts to avoid scrutiny associated with the opioids within which MAT drugs are classified. Buprenorphine was previously classified by the Drug Enforcement Agency (DEA) as a Schedule V drug under the Controlled Substances Act until it was rescheduled in 2002 to Schedule III based on FDA's recommendation. DEA noted, however, that there was "little abuse or diversion of buprenorphine…in the U.S."[4]

This upscheduling was implemented two decades ago, before the opioid crisis, and based on a perception of risk for abuse and misuse of buprenorphine that has not come to pass. Data show that, indeed, there has been little misuse[5] of buprenorphine products indicated for treatment of OUD.[6] And, when there is, it is mainly for self-medication by OUD patients in need of medication rather than people seeking a high.[7] The National Institute on Drug Abuse notes that "a majority of those who used illicit buprenorphine reported that they used it for therapeutic purposes (i.e., to reduce withdrawal symptoms, reduce heroin use, etc.) Ninety-seven percent reported using it to prevent cravings, 90 percent to prevent withdrawal, and 29 percent to save money." Further, the Institute reports that "[I]llicit use of buprenorphine decreased as individuals had access to treatment."[8] Data from a

[4] Schedule of Controlled Substances: Proposed Rule: Rescheduling of Buprenorphine From Schedule V to Schedule III, 21 CFR 1308 (2002) at https://www.federalregister.gov/documents/2002/03/21/02-6767/schedule-of-controlled-substances-proposed-rule-rescheduling-of-buprenorphine-from-schedule-v-to

[5] Cicero, T. and Inciardi, J., Potential for Abuse of Buprenorphine in Office-Based Treatment of Opioid Dependence, N Engl J Med 2005; 353:1963-1865 at https://www.nejm.org/doi/10.1056/NEJM200510273531724

[6] Buprenorphine misuse decreased among U.S. adults with opioid use disorder from 2015-2019 | National Institute on Drug Abuse (NIDA)

[7] Schuman-Olivier Z, Albanese M, Nelson SE, Roland L, Puopolo F, Klinker L, Shaffer HJ. Self-treatment: illicit buprenorphine use by opioid-dependent treatment seekers. J Subst Abuse Treat. 2010 Jul;39(1):41-50. doi: 10.1016/j.jsat.2010.03.014. PMID: 20434868 at https://pubmed.ncbi.nlm.nih.gov/20434868/

[8] "*Both buprenorphine and buprenorphine/naloxone formulations can interfere with the effects of full opioid agonists, such as heroin, and can precipitate withdrawal in individuals with opioid dependence. Two U.S. surveys of people with opioid use disorder found that a majority of those who used illicit buprenorphine reported that they used it for therapeutic purposes (i.e., to reduce withdrawal symptoms, reduce heroin use, etc.). Ninety-seven percent reported using it to prevent cravings, 90 percent to prevent withdrawal, and 29 percent to save money Illicit use of buprenorphine decreased as individuals had access to treatment.The minority proportion of people who use buprenorphine illicitly to get high (ranging from 8 to 25 percent) has been shown to decrease over time, which could suggest that people abandon this goal after they experience the drug's blunted rewarding effects. Indeed, patients in treatment for opioid use disorder rarely endorse buprenorphine as the primary drug of misuse*." DrugAbuse.gov, What is the treatment need versus the diversion risk for opioid use disorder treatment?, Research Report, National Institute on Drug Abuse (2018) at at https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/what-treatment-need-versus-diversion-risk-opioid-use-disorder-treatment

meta-analysis of rescheduling shows that 'down-scheduling' increases prescription of the medication and may decrease substitution of the down scheduled product for a more restrictive and dangerous product.[9]

Successful OUD treatment with buprenorphine hinges not only on qualified providers and valid prescriptions, but also on ensuring that patients are able to fill their prescriptions to start and stay on their recovery program. In addition, clinicians adopting MAT within their practices may become discouraged if they are unable to ensure that patients have what they need to maintain recovery. We suggest that Congress:

- pass legislation eliminating the DATA 2000 waiver
- pass legislation removing prior authorization on MAT in Medicaid programs
- require HHS to reexamine its decades-old recommendation to move buprenorphine indicated for OUD to Schedule III; and
- gain an understanding of private wholesaler, distributor, and pharmacy efforts that limit access to MAT medications, including rationing and algorithms intended to avoid scrutiny associated with historic patterns of dumping massive amounts of opioids in the market. MAT should ether be exempted from opioid quotas and/or have its own quotas separate from opioids.

Although removing barriers to MAT drugs is essential to ensuring that OUD patients have a meaningful opportunity for recovery, access to counseling and behavioral interventions is likely to remain tenuous due to the logistic challenges of physician office coordination with mental health providers as well as insufficient capacity.

- Although 93% of healthcare providers think most MAT patients would benefit from counseling, only 36% report an adequate number of counselors in their area.[10]
- In a survey of 400 buprenorphine patients, 41% reported that they did not receive counseling in their first 30 days of treatment.[11]

As further detailed below, offering an alternative modality for delivering behavioral therapy through digital therapeutics and remote behavioral health services would, if deployed within a clinician-patient relationship, augment the limited resources available to address the significant capacity constraints and help clinicians and their patients avoid the binary choice between MAT medication alone and no OUD treatment.

Continued efforts to increase access to buprenorphine and initiatives that expand access to

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[9] Caulkins, J., et al Outcomes associated with scheduling or up-scheduling controlled substances, Intl J. Drug Policy (2021) https://www.sciencedirect.com/science/article/pii/S0955395921000098?via%3Dihub.

[10] Researchers specifically surveyed physicians actively prescribing buprenorphine (N = 1174). Substance Abuse and Mental Health Services Administration. Medication and Counseling Treatment. 2020. Retrieved from: https://www.samhsa.gov/medication-assisted-treatment/treatment.

[11] Lin L, et al. *Addict Behav*. 2019; 93: 72-77. **3.** Fiellin DA. *J Addict Med*. 2007; 1: 62–67.

alternative modalities for delivering behavioral and mental health supports can help people with OUD manage their disorder and can ultimately save lives.

Access to mental health and substance use disorder treatment in general

There is a substantial relationship between mental health and substance use disorders, and many people are subject to both. The 2017 analysis of the National Epidemiological Survey on Alcohol and Related Conditions (NESARC)[i] (Chestnut Health Systems, Bloomington, IL 1998) revealed that of adults reporting "alcohol dependence," 54% had experienced an anxiety disorder in their lifetime and 34% had experienced a personality disorder in their lifetime.[12] According to the 2016 Surgeon General's report on substance use disorders, "of the 20.8 million people aged 12 or older who had a substance use disorder during the past year, about 2.7 million (13 percent) had both an alcohol use and an illicit drug use disorder, and 41.2 percent also had a mental illness. It is estimated that 30-60 percent of patients seeking treatment for alcohol use disorder meet criteria for PTSD and approximately one third of individuals who have experienced PTSD have also experienced alcohol dependence at some point in their lives."[13] Depression, too, is often a coexisting condition in individuals with problematic drinking and other SUDS, including OUD.

Inequities in unaddressed mental illness is a long-standing problem impacting communities of color and other under-served populations:

- In 2018, 56.7% of the overall US population reported receiving no treatment for their mental illness
- For Black and Latinx adults, the treatment deficiencies were more pronounced, with 69.4% (Black) and 67.1% (Latinx) reporting that their mental illness was untreated [14]
- Black and Latinx patients not only have reduced access to needed treatment, but frequently terminate treatment prematurely, and generally receive care that is less culturally responsive than their white counterparts[15]
- Primary care providers (PCPs) are responsible for 60% of mental healthcare, and prescribe 79% of antidepressants with little to no specialist services or support

The COVID-19 PHE has significantly challenged the health system's ability to address the multiple threats of increased need for substance use and mental health treatment resources due to social

[12] Grant BF, Chou SP, Saha TD, et al. Prevalence of 12-Month Alcohol Use, High-Risk Drinking, and DSM-IV Alcohol Use Disorder in the United States, 2001-2002 to 2012-2013: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. JAMA Psychiatry. 2017;74(9):911–923. doi:10.1001/jamapsychiatry.2017.2161

[13] Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (samhsa.gov)

[14] Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. (Submitted by OBHE), Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. (Submitted by OBHE) (samhsa.gov)

[15] See, e.g., The Opioid Crisis and the Black/African American Population: An Urgent Issue | SAMHSA Publications and Digital Products

isolation within the pandemic, increasing racial inequities in the economic and health burdens associated with COVID-19, and significant provider capacity constraints. Digital therapeutics can be an important option for expanding access to mental health and substance use care and improving health equity, but only if effective digital therapeutics are utilized and paid for. Digital therapeutics may be particularly helpful in communities that have been traditionally underserved in that they not only offer mobility and access to evidenced-based solutions but have potential for additional benefits of privacy (reducing the patient's concerns about stigma), consistency (reducing potential biases associated with a live therapist) and impartiality.

FDA appeared to recognize that emergence of digital health devices, including digital therapeutics, creates opportunities to improve health system efficiencies and augment capacity to address public health concerns with its April 14, 2020 guidance document entitled "Enforcement Policy for Digital Health Devices for Treating Psychiatric Disorders During the Coronavirus Disease 2019 (COVID-19) Public Health Emergency."[16] The Agency's rationale for issuing this final guidance document was:

> to provide a policy to help expand the availability of digital health therapeutic devices for psychiatric disorders to facilitate consumer and patient use while reducing user and healthcare provider contact and potential exposure to COVID-19 during this pandemic.

The FDA guidance announced that "[g]iven these public health benefits, for the duration of the COVID-19 public health emergency, FDA does not intend to object to the distribution and use of computerized behavioral therapy devices and other digital health therapeutic devices for psychiatric disorders, . . . where such devices do not create an undue risk in light of the public health emergency." Among the types of products specifically delineated as low-risk and within the purview of the guidance are those that "implement condition-specific therapy for temporary relief of symptoms through modalities, such as Acceptance Commitment Therapy, Cognitive Behavioral Therapy, or other types of therapies."[17]

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) within the National Institute of Health (NIH) has also acknowledged that access to digital therapeutics could improve patient outcomes[18]

> Electronic health (eHealth) technologies are poised to transform theories of behavior change and models of behavioral health care through real-time monitoring of physical and cognitive states and delivery of personalized interventions that can prevent relapse when and where needed.

Although FDA prioritized access to alternative modalities to address mental and behavioral health over a year and a half ago, federal payers have not implemented the reimbursement mechanisms necessary to translate commercial availability into patient access. As you are likely aware, CMS has historically faced challenges in incorporating new technologies into a statutory framework that could not have contemplated advances in digital information and innovative modalities for delivering care. Although

[16] https://www.regulations.gov/document?D=FDA-2020-D-1138-0078.
[17] Id.
[18] https://pubs.niaaa.nih.gov/publications/aa88/aa88.htm

the development of digital therapeutics is relatively new, the services they deliver are established and generally covered.

Moreover, medical devices that use software and communicate information to health care providers, including remote monitoring devices and surgical/treatment planning software tools, as well as technology-based psychological and neuropsychological testing have been reimbursed as Medicare-covered items or services.

We suggest that CMS adoption of a set of digital therapeutics "miscellaneous" or "unspecified" HCPCS codes would be a pragmatic mechanism enabling clinicians to report the costs associated with dispensing or otherwise enabling access to evidence-based digital therapeutics This would also ensure that payers have the opportunity to differentiate technologies with a sufficiently robust evidentiary basis from those with limited evidence, enable payers to appropriately set payment rates. For example, cognitive behavioral therapy (CBT) digital therapeutics can be offered in relatively simple, linear formats with patient progression through modules in a manner similar to moving through the chapters of an e-book. The patient gains the benefit of the information presented, but the device cannot generate data or present information that responds to the patient or their therapeutic progress and goals. Orexo's digital therapeutics build on the artificial intelligence (AI) software broca® and simulate interaction between the patient and an empathetic physician or therapist to generate a tailored, patient-specific therapeutic intervention. The interventions are, therefore, both quantitatively and qualitatively different, and it is important that payer mechanisms are sufficiently granular to differentiate technologies and ensure access to the therapeutic that best matches the patient's needs.

- Congress should analyze CMS' upcoming final PFS rule and supplement those decisions to ensure a clear set of reimbursement mechanisms to accommodate these technologies, including the nuances that recognize differences in technology complexity, evidence supporting its use, condition-specific needs and priorities, and the balance of risks, costs, and benefits for patients and the health care system.

What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers?

Orexo urges Congress to incentivize state and local initiatives that incorporate technology to improve patient access to the medications they need as well as behavioral therapy, psychosocial supports and other assistance. Patients often enter the health system for SUD and other mental health disorders through crises such as overdose, encounters with law enforcement (e.g., driving while intoxicated, suicidal ideation, overt drug use, and disruptive behaviors). Access to appropriate care should both responds to the individual's immediate needs and facilitate access to a continuum of care including:

- Medications, if appropriate
- Identification of providers with sufficient capacity
- Online resources
- Digital therapeutics addressing behavioral and mental health needs

- Tools to improve adherence to treatment

Encouraging state and local programs that augment provider capacity and offer a bridge to recovery when individuals are identified as at-risk of poor outcomes or motivated to seek treatment would improve care in communities with high unmet needs.

In addition, Orexo suggests convening a collaborative process that includes federal agencies, state and local officials, payers, providers, manufacturers, and consumers to chart a path forward for adoption of digital therapeutics and other technologies that can reduce the real-world impact of provider capacity constraints, promote mental health and substance use equity, and address the growing crisis in America. We welcome the opportunity to discuss innovative approaches that can leverage technology with other interventions to improve patient outcomes and reduce health care costs.

Thank you for the opportunity to provide comments. Please do not hesitate to contact me, or our government affairs consultant, Saira Sultan, at 202-360-9985.

Sincerely,

Dennis Urbaniak

Executive Vice President Digital Therapeutics

Orexo US Inc.