Chair Nosse and Members of the Committee,

My name is Moxie Loeffler and I'm the Public Policy Chair for the Oregon Society of Addiction Medicine (ORSAM), your state ASAM chapter. I live in Eugene in Senator Prozanski's and Representative Fragala's districts. I am an Addiction Medicine and Internal Medicine physician and I'm here to ask you to support HB2270 to raise reimbursement rates for the care we provide. This can lead to improvements in both the quantity and quality of care.

Addiction Medicine Physicians offer comprehensive treatment for all levels of addiction severity in the outpatient and inpatient environments. We treat acute and chronic:

- Opioid Use Disorder
- Alcohol Use Disorder, Alcohol misuse, and at-risk alcohol use
- Benzodiazepine Use Disorder
- Tobacco Use Disorder
- Medical and Psychiatric complications of Addiction

Medicaid reimbursement rates for Addiction Medicine are too low. This means that our workforce struggles to meet our state's needs. Healthcare organizations cannot afford to build the care that patients need because of the low rates.

Oregon consistently ranks at the top among states for the greatest need for Substance Use Disorder (SUD) treatment (i.e. mismatch between resources available and the prevalence of disease, according to the National Survey on Drug Use and Health (NSDUH)).

The United States has the highest rate of death from drug use disorders in the world.[2]
Researchers estimated that addiction caused a total burden of Disability-Adjusted Life Years (DALY) of 13.83 million due to drug overdoses over a two-year period. COVID-19's DALY then was 15 million.[3]

Oregon Health Authority (OHA) reported in May 2024 that it would cost $6.85 billion to close the gaps in Oregon's Addiction Medicine treatment network.[4] Unfortunately, the OHA report did not thoroughly address the Addiction Medicine Physician, Nurse Practitioner, and Physician Assistant workforce shortage.[4] Our role in treating acute and chronic addiction is crucial to our patients' health. Without access to medical clinicians, counselors and peer support workers will be ill-equipped to stabilize patients and prevent deaths.

The Public Consulting Consulting Group issued a report on improvements needed in residential addiction treatment to Governor Kotek in June 2024 stating that Oregon needs (by Q4 2025):[6]

- Secure Residential Treatment Facility (SRTF) beds: 587 -- 34% increase
- SUD Residential treatment beds: 2,357 -- 166% increase

- Withdrawal management beds: 571 -- 180% increase

The OHA report noted that Oregon needs over 1,100 more buprenorphine prescribers to meet the need for Opioid Use Disorder treatment.[4]

Reimbursement for medical services historically focused on clinicians and not on patient needs, public health impacts, or state spending on the externalized costs of untreated disease (such as foster care and incarceration). Payment models that use Current Procedural Technology (CPT) codes in the 1960s and Relative Value Units (RVUs) in the 1990s are based on what physicians were able to negotiate because of the time, skill, and training necessary for the services they provided. The American Board of Medical Specialties (ABMS) recognized Addiction Medicine as a specialty in 2016, decades later.[5] The payment system was designed without us, and without regard for our patients.

Poorly regulated health insurance with low reimbursement rates (especially through Medicaid) has resulted in insufficient, temporary funding of hospital, Emergency Department, and ambulatory clinic consult services. Grants only help our Addiction Medicine Physician workforce temporarily and they are not routinely required to start and sustain medical practice in other subspecialty fields such as Cardiology, Oncology, Surgery, Obstetrics and Gynecology, Nephrology, and Neurology. Inequitable treatment and exclusion from the healthcare system has resulted in unequal and hazardous funding conditions for the field of Addiction Medicine.

While our state government may deem it unaffordable to fund the entire network that we need, a high impact statewide solution exists. Addiction Medicine is a time-intensive practice, and it is reimbursed poorly given its high value. Well-regulated health insurance markets with better reimbursement would result in innovations and the birth of new robust systems. Public, nonprofit, and for-profit organizations would find it feasible to offer Addiction Medicine services following substantial reform.

Oregon can create incentives to build high quality care with abundant network by changing the economic landscape. We ought to reimburse Addiction Medicine Physician care given within healthcare organizations at higher rates than the usual rate for Medicaid.

The first meetings about Medicaid Addiction rates in 2025 ought to address, among other issues:

- Whether any “H” codes ought to be added immediately to the list of codes that require reimbursement increases.
- How to Define eligible codes including both E/M and HCPCS including “incident to” services such as peer-delivered, QMHP/QMHA, and team-based medical and psychosocial services
- How to reimburse care given at the new ASAM Criteria Levels of Care 1.7 and 2.7 based upon Medical Director Qualifications (1.7 Medically Monitored Outpatient Care; 2.7 Medically Monitored Intensive Outpatient Care).[9]
- Whether to increase billing for codes other than H0020 at Opioid Treatment Programs (OTPs). (Such as counseling and provider visits).
- Provider and healthcare administrator awareness of rate increases and technical support services available to optimize billing
- Whether to recommend to the legislature an annual rate increase based on the cost of living (eg. 3-4%)
- How OHA can effectively ensure that Coordinated Care Organizations (CCOs) pay at least the DMAP reimbursement rates without delay.

Addiction Medicine and Addiction Psychiatry physicians work in both subspecialty programs and in general medicine environments, and we need Medicaid to pay more for Substance Use Disorder care

regardless of the setting in which it is delivered. We need to have a “no wrong door” approach to this public health problem, which means that patients ought to meet highly skilled Addiction Medicine physicians in every care environment.

The type of care we provide is time-intensive because of the complexity and because Medicaid patients with SUD often face many social and economic challenges. Primary care pays more than Addiction Medicine because we often use the same time-based billing codes but we cannot see as many patients per day (primary care: 18-24 patients/day; Addiction Medicine: 8-16 patients/day).

ORSAM’s members have reported the following struggles to maintain and build Addiction Medicine care:

- For nine years, a primary care physician tried to get time in her schedule dedicated to patients with SUD. Healthcare administrators said that they could not afford to alter her schedule.
- The director of a safety net buprenorphine practice has been told that this clinic is not financially sustainable.
- Two Addiction Medicine consultant physicians at different hospitals are funded by grant programs that will last only 1-2 years.
- A physician was offered jobs as a primary care Medical Director, but told that Addiction Medicine services would only be financially feasible for privately insured patients.

I live in Lane County, which has 380,000 residents and for eight years at a Federally Qualified Health Center (FQHC), I was the only Addiction Medicine physician who treated every SUD and accepted all patients regardless of insurance type. I have treated hundreds of Medicaid patients for fentanyl use disorder and other SUDs. I did not want to give up on our low-income, addicted Oregonians.

When I left my job, I decided to wait until I could find a practice that would be able to accept an unlimited number of Medicaid patients with substance use disorder, so I was unemployed for seven months. During that time, I could have treated 2,240 patients. Fortunately, I now work for PeaceHealth, where I can see any patient. Oregon needs to regulate insurance coverage in ways that will create more jobs like the one I have now.

Physicians in my field know how to expand access to care, but we need Medicaid rates that will make that possible. Oregon’s 105 Addiction Medicine and 17 Addiction Psychiatry physicians could respond to the opioid epidemic if we changed the payments.

HB2270 will require the state government to review the billing codes we use and recommend rates that will fund the kind of care that will save Oregonians and reduce the burden of addiction-related death and disability.

Increased rates will enable us to hire sufficient staffing and retain highly skilled workers in counseling, peer support, nursing, and medicine.

We can’t afford not to act to improve our Addiction Medicine treatment network. Please support HB2270. This bill is our best hope to save lives and reduce suffering.

Thank you,

Moxie Loeffler, DO, MPH, Fellow of the American Society of Addiction Medicine

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