**STATEMENT**

**of**

**Malik Burnett, MD, MBA, MPH**

**Vice Chair, Public Policy Committee**

**American Society of Addiction Medicine**

**U.S. Senate Special Committee on Aging**

**Re: Combating the Opioid Epidemic**

**February 26, 2025**

**STATEMENT**

**of**

**Malik Burnett, MD, MBA, MPH**
**Vice Chair, Public Policy Committee**
**American Society of Addiction Medicine**

**U.S. Senate Special Committee on Aging**
**Re: Combating the Opioid Epidemic**

**February 26, 2025**

Chairman Scott, Ranking Member Gillibrand, and esteemed Members of the Special Committee on Aging, thank you for inviting me to participate in today's critically important hearing.

My name is Dr. Malik Burnett. I am a board-certified addiction specialist physician who takes care of patients with addiction and co-occurring conditions in Baltimore, Maryland. I serve as the medical director of several community opioid treatment programs, an Adjunct Assistant Professor at the University of Maryland, and a consultant for the Maryland Addiction Consultation Service.

Today, I am testifying in my capacity as Vice Chair of the Public Policy Committee of the American Society of Addiction Medicine, known as ASAM. ASAM is a national medical society representing over 8,000 physicians and other clinicians who specialize in the prevention and treatment of addiction.

I want to begin by talking about Baltimore and its forgotten generation – older adults born between 1951 and 1970, particularly older Black men.[1] In my city, almost one in three drug overdose deaths come from this demographic.[1] Indeed, illicitly manufactured synthetic opioids are among the deadliest health threats they face. Many of these men have struggled with addiction for years, but today, there is no margin for error. A single relapse can leave them at the mercy of a lethal dose of fentanyl and other synthetic drugs.

While addiction is a treatable, chronic medical disease, it is also one of the most complex in medicine. It involves interactions among brain circuits, genetics, the environment, and an individual's life experiences. As a result, solutions to our nation's addiction and overdose crisis can be equally complex and interconnected.

Supply-side approaches – like the DEA's record seizure of fentanyl pills in 2023[2] – are important to public safety, but yield little net benefit if demand-side interventions remain inaccessible, underfunded, or undermined. Drug cartels can quickly replace confiscated synthetic drugs – no crops, farmland, or irrigation required – just some precursor chemicals, a few chemists, and hundreds of traffickers, all making more money than most of us will see in a lifetime.

The good news? Evidence-based addiction treatment works, and it as effective as treatments for other chronic diseases.[3]

As a physician, I have personally witnessed hundreds of patients' lives transformed by addiction treatment. Practicing addiction medicine is an immensely satisfying profession, because I get to see people get *really well* - they restore their marriages, rejoin the workforce, leave criminal activity, improve their mental and physical wellbeing, reunite with their children, and yes – escape the grasp of drugs cartels. Addiction treatment not only improves their lives, but the lives of those around them.

We are fortunate to live during a time when effective, evidence-based treatments exist for opioid use disorder. These treatments cut the risk of death, decrease or eliminate drug use, and facilitate transitions into healthy, productive roles in society.[4,5] **Yet, tens of thousands of people in the US continue to die from illicit opioids annually.**

**How is this possible?**

Unfortunately, the people who need these treatments the most – people with opioid use disorder – are not getting the lifesaving care they need, when they need it. In fact, this treatment gap has barely budged over the last decade.[6] **We will not end this opioid epidemic until evidence-based addiction treatment is easier to get than illicit opioids.**

For many Americans, especially in rural areas, evidence-based addiction treatment can be impossible to find.[7,8] Ease of treatment access is critically important, because people with addiction often experience a brief window of time between desiring treatment and experiencing painful withdrawal symptoms – symptoms that cheap fentanyl, which can be easier to get than addiction medications, can temporarily stop in an instant.

Easier access to addiction treatment cannot happen without a substantially larger addiction treatment workforce,[9] including more addiction specialist physicians. Specialist physicians like me are critical for helping patients with complex, interconnected health conditions, for leading interdisciplinary care teams, and for serving as mentors to primary care clinicians who would like to integrate addiction treatment into their practices but need greater guidance to do so. **Increased federal funding for addiction medicine and addiction psychiatry fellowships and financial incentives to encourage more physicians to enter these training programs are sorely needed to ensure every community has access to high-quality addiction treatment.**

**In addition, federal law must be amended to allow these addiction specialist physicians to prescribe methadone for opioid use disorder that can be dispensed from community pharmacies.** Today, only about 2,000 clinics dispense methadone for opioid use disorder, and they are lacking in 80% of US counties.[10] Methadone for opioid use disorder (but not for pain) has more federal restrictions than just about any other FDA-approved medication. It has been caught in bureaucratic red tape for nearly fifty years – despite an opioid epidemic that has continued to worsen. **Allowing states to regulate their methadone treatment, without undue federal restrictions, could lead to the type of innovation needed in opioid addiction treatment in America.**

Yet, connecting individuals to treatment is not enough – they must also be able to afford their care. Medicaid and Medicare are major insurers for many people with opioid addiction, making it essential that their policies facilitate, rather than hinder, access. For example, if states are expected to implement Medicaid work requirements, then they also should have the ability to

exempt beneficiaries with substance use disorders that make it difficult for them to meet those requirements. While completing addiction treatment can increase the likelihood of employment,[11] beneficiaries struggling with severe, unmanaged substance use disorders and associated criminal records may not be able to obtain or maintain employment. Without such an exemption, our nation could face an unnecessary increase in expensive emergency room visits, as well as in overdose deaths.[12]

Many mental health therapists,[13] opioid treatment programs,[14] and buprenorphine prescribers[15] do not accept Medicaid, largely reflecting the program's administrative burdens and low reimbursement rates.[13] **Congress should remove these burdens and increase Medicaid rates to change this equation.** In the meantime, addiction treatment providers who do not accept Medicaid are essentially unavailable to the approximately 40% of nonelderly adults with opioid use disorder who rely on Medicaid.[16]

Medicare and Medicaid must also cover the full continuum of addiction care. (See the enclosed handout on *The ASAM Criteria*). **Surprisingly, Medicare does not cover non-hospital-based residential addiction treatment,[17] even though the rate of drug overdose death rates quadrupled among older Americans between 2002 and 2021.[18] This must change. Further, enforcement of mental health and addiction parity must be strengthened by requiring robust data collection and evaluation, levying civil penalties for parity violations, and incentivizing state regulators to be more robust in their enforcement.**[19] Consumers should not have the burden of initiating investigations into insurance practices that may violate parity, especially as many addiction treatment patients lack financial resources or legal knowledge.

Additionally, countless studies indicate that the stigma of addiction prevents treatment access. Even when people recognize they have a problem with drugs or alcohol, they are too embarrassed or scared to talk to their physician about it.[20] Stigma is arguably the most difficult barrier to address, as it is so entrenched in society.[21] **The federal government should stop wasting money on incarcerating people for non-violent drug offenses and must continue to emphasize that addiction is a disease, not a moral failing.** When government resources are spent on incarcerating people with addiction for non-violent drug offenses, this message gets muddled, and society continues to view addiction as a moral failing, disincentivizing people from seeking help.[21] Incarcerating people for low-level drug crimes is also incredibly fiscally irresponsible. Every dollar spent on addiction treatment saves $7 of justice system resources.[22] Research continues to show that treatment can reduce illicit drug use and associated criminal activity.[23]

People already in the criminal legal system also need better addiction treatment. **Congress should eliminate Medicaid's inmate exclusion, and federal funding for prisons and jails should be contingent on providing evidence-based addiction treatment – to ensure that taxpayer money is not wasted on a revolving door of incarceration.**[24] The Department of Justice should continue investigating criminal legal institutions that refuse to offer or permit use of methadone and buprenorphine.[25] There is a high risk of overdose death for people leaving jail or prison,[26] as they lose opioids tolerance but may return to drug use without a connection to community-based treatment. Prisons and jails should be incentivized to hire professionals, like social workers, to connect people who are reentering the community to continued addiction treatment, housing, and employment services – critical services that reduce the chances of returning to environments that involved drug use.[27]

In closing, thank you for the opportunity to share my perspective and expertise today. Prior to this hearing, I had the privilege of reading RAND's report on *America's Opioid Ecosystem* and related policy ideas.[28] Throughout it, there is one fundamental question: *Who owns this?*

Whether it is funding the training of more addiction specialists; ensuring that they can legally prescribe methadone; closing the dangerous Medicare coverage gap for residential addiction treatment; equipping the criminal legal system to provide evidence-based addiction care; enforcing mental health and addiction parity, or avoiding harmful cuts to Medicaid, the answer is the same: *Congress owns this.*

Let us work together to save lives.

Thank you, and I look forward to answering your questions.

---

REFERENCES


1. Thieme N, Zhu A, Gallagher J. Seniors in Baltimore Are Being Devastated by Drugs: 5 Takeaways. *The New York Times*. June 3, 2024. https://www.nytimes.com/2024/06/03/us/baltimore-opioid-epidemic-seniors-takeaways.html
2. Operation Engage Seattle-Top Local Drug Threat: Fentanyl. Accessed February 20, 2025. https://www.dea.gov/engage/operation-engage-seattle#:~:text=In%20calendar%20year%202023%2C%20DEA,enough%20to%20kill%20every%20American
3. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *Jama*. Oct 4 2000;284(13):1689-95. doi:10.1001/jama.284.13.1689
4. Santo T, Jr., Clark B, Hickman M, et al. Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 2021;78(9):979-993. doi:10.1001/jamapsychiatry.2021.0976
5. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: Systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550. doi:10.1136/bmj.j1550
6. Krawczyk N, Rivera BD, Jent V, Keyes KM, Jones CM, Cerdá M. Has the treatment gap for opioid use disorder narrowed in the U.S.?: A yearly assessment from 2010 to 2019". *Int J Drug Policy*. Jul 19 2022:103786. doi:10.1016/j.drugpo.2022.103786
7. Andrilla CHA, Patterson DG. Tracking the geographic distribution and growth of clinicians with a DEA waiver to prescribe buprenorphine to treat opioid use disorder. *The Journal of Rural Health*. Mar 18 2021;doi:10.1111/jrh.12569
8. Stopka TJ, Estadt AT, Leichtling G, et al. Barriers to opioid use disorder treatment among people who use drugs in the rural United States: A qualitative, multi-site study. *Soc Sci Med*. Feb 13 2024;346:116660. doi:10.1016/j.socscimed.2024.116660

9. Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication-assisted treatment. *Am J Public Health*. 2015;105:e55-e63. doi:10.2105/AJPH.2015.302664
10. J.H. Duff and J.A. Carter, "Location of Medication-Assisted Treatment for Opioid Addiction: In Brief" (Congressional Research Service, 2019), https://www.everycrsreport.com/files/20190624_R45782_ed39091fadf888655ebd69729c3180c3f7e550f6.pdf
11. Zarkin GA, Dunlap LJ, Bray JW, Wechsberg WM. The effect of treatment completion and length of stay on employment and crime in outpatient drug-free treatment. *Journal of Substance Abuse Treatment*. 2002;23(4):261-271. doi:10.1016/S0740-5472(02)00273-8
12. Andrews CM, Humphreys K, Grogan CM. How Medicaid work requirements could exacerbate the opioid epidemic. *Am J Drug Alcohol Abuse*. 2020;46(1):1-3. doi:10.1080/00952990.2019.1686760
13. Zhu JM, Huntington A, Haeder S, Wolk C, McConnell KJ. Insurance acceptance and cash pay rates for psychotherapy in the US. *Health Aff Sch*. Sep 2024;2(9):qxae110. doi:10.1093/haschl/qxae110
14. Substance Abuse and Mental Health Services Administration. (2023). National Substance Use and Mental Health Services Survey (N-SUMHSS) 2022: Data on Substance Use and Mental Health Treatment Facilities (SAMHSA Publication No. PEP23-07-00-002). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt42714/NSUMHSS-Annual-Detailed-Tables-22.pdf
15. Saunders H, Britton E, Cunningham P, Saxe Walker L, Harrell A, Scialli A, Lowe J. Medicaid participation among practitioners authorized to prescribe buprenorphine. J Subst Abuse Treat. 2022 Feb;133:108513. doi: 10.1016/j.jsat.2021.108513. Epub 2021 Jun 1. PMID: 34148758.
16. Orgera K, Tolbert J. The opioid epidemic and medicaid's role in facilitating access to treatment. Kaiser Family Foundation. http://files.kff.org/attachment/Issue-Brief-The-Opioid-Epidemic-and-Medicaids-Role-in-Facilitating-Access-to-Treatment
17. Legal Action Center. *Medicare's Expanded Coverage of Substance Use Disorder Treatment: Important Progress and Recommendations to Fill Remaining Gaps*. 2024.
18. Humphreys K, Shover CL. Twenty-Year Trends in Drug Overdose Fatalities Among Older Adults in the US. *JAMA Psychiatry*. May 1 2023;80(5):518-520. doi:10.1001/jamapsychiatry.2022.5159
19. Ard JP. An Unfulfilled Promise: Ineffective Enforcement of Mental Health Parity. *Annals of Health Law*. 2017;26 70-85.
20. Farhoudian, A., Razaghi, E., Hooshyari, Z., Noroozi, A., Pilevari, A., Mokri, A., Mohammadi, M. R., & Malekinejad, M. (2022). Barriers and Facilitators to Substance Use Disorder Treatment: An Overview of Systematic Reviews. Substance abuse : research and treatment, 16, 11782218221118462. https://doi.org/10.1177/11782218221118462
21. Tsai AC, Kiang MV, Barnett ML, et al. Stigma as a fundamental hindrance to the United States opioid overdose crisis response. *PLoS Med*. Nov 2019;16(11):e1002969. doi:10.1371/journal.pmed.1002969
22. Fardone, E., Montoya, I. D., Schackman, B. R., & McCollister, K. E. (2023). Economic benefits of substance use disorder treatment: A systematic literature review of economic evaluation studies from 2003 to 2021. Journal of substance use and addiction treatment, 152, 209084. https://doi.org/10.1016/j.josat.2023.209084

23. Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: improving public health and safety. *JAMA*, *301*(2), 183–190. https://doi.org/10.1001/jama.2008.976
24. Daley M, Love CT, Shepard DS, Petersen CB, White KL, Hall FB. Cost-Effectiveness of Connecticut's In-Prison Substance Abuse Treatment. *Journal of Offender Rehabilitation*. 2004/10/07 2004;39(3):69-92. doi:10.1300/J076v39n03_04
25. The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery 2022. Accessed June 2, 2023. https://archive.ada.gov/opioid_guidance.pdf
26. Binswanger IA, Blatchford PJ, Mueller SR, Stern MF. Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009. *Ann Intern Med*. 2013;159:592-600. doi:10.7326/0003-4819-159-9-201311050-00005
27. Hoffman KA, Thompson E, Gaeta Gazzola M, et al. "Just fighting for my life to stay alive": a qualitative investigation of barriers and facilitators to community re-entry among people with opioid use disorder and incarceration histories. *Addict Sci Clin Pract*. Mar 21 2023;18(1):16. doi:10.1186/s13722-023-00377-y
28. *America's Opioid Ecosystem: How Leveraging System Interactions Can Help Curb Addiction,Overdose, and Other Harms. The Ecosystem Approach to Opioid Policy.* RAND Corporation; 2023. https://www.rand.org/pubs/visualizations/DVA604-1/ecosystem-approach-to-opioid-policy.html