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**COALITION OF MEDICATION-ASSISTED TREATMENT PROVIDERS AND  
ADVOCATES** before the Joint Senate Task Force on Opioids, Addiction & Overdose  
Prevention

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Prepared by the Coalition of Medication Assisted Treatment Providers and Advocates  
Albany, New York

November 15, 2019

Thank you for allowing COMPACT to submit testimony today and thank you for all the work the Senate has done over the last several years to combat New York's opioid epidemic.

Opioid addiction is a growing public health crisis that kills people every day in New York, with 3,894 people dying in 2016 alone. In response, New York State has made some significant policy inroads to expand treatment.

However, in order to finally reverse the growing trend of opioid addiction and death, it is imperative that the State continue to break down barriers to treatment and invest in programs that are accessible to everyone.

The Opioid Treatment Programs (OTPs) are on the frontlines of fighting the epidemic. These programs are essential providers with a specialized mission to treat individuals with opioid dependence through Medication Assisted Treatment (MAT). There are three FDA-approved drugs used in MAT: Methadone, Buprenorphine, and extended-release injectable Naltrexone.

In April of 2018, the US Assistant Secretary of Health declared MAT as the "standard of care" for the treatment of opioid addiction, underscoring the role that MAT plays in combating the epidemic.

There are 107 OTP programs in New York serving over 41,000 New Yorkers or one-third of the people in the NYS Office of Alcoholism and Substance Abuse Services system. OTP treatment is comprehensive and multi-disciplinary. Treatment includes counseling; physical exams; and medications, with an average patient visit of 3.5 times per week.

OTPs operate within strict regulations and accreditation standards, which authorize an unlimited federal capacity to dispense Buprenorphine. Further, OTPs serve as treatment hubs, providing support for independent physicians who are qualified to prescribe buprenorphine, but whose patients need more intensive care and counseling.

In order to ensure that all New Yorkers can access care, New York must focus its response in the following manner:

- **Limit copays for treatment at Opioid Treatment Programs.** COMPA is grateful for the language in the FY 2019-20 State Budget that requires copays for SUD treatment to be in-line with copays for primary care. However, it is also necessary to limit the frequency of copays at OTPs, because insurers don't consider the regularity of patient visits. For example, at the start of treatment, Methadone patients are required by federal law to receive treatment 6 times a week for 90 days. Insurers can impose a copay each day. High, daily copays are cost-prohibitive for people seeking treatment.

We ask the Task Force to support A.972-A (Rosenthal)/S.4643-A (Harckham), which would prohibit copays during treatment at an Opioid Treatment Program.

- **Provide open access to MAT by removing prior authorizations.** Thank you for passing two separate bills that prohibit prior authorizations for MAT under commercial insurance and Medicaid respectively (A.2904 (Quart)/S.4808 (Harckham) and A.7246-A (Rosenthal)/S.5935 (Harckham). These bills are before the Governor and we mention them here to underscore their importance.

Prior authorizations can lead to unnecessary delays in treatment, which can have devastating effects for patients.

- **Develop a comprehensive program for MAT in correctional facilities and parole programs.** Nationally, nearly one quarter of people in jails and prisons are addicted to opioids and upon release they are 130-times more likely to die from an overdose than the general population. In order to significantly reduce fatalities due to opioid addiction, MAT should be required in jails and state prisons.

COMPA thanks the Senate for passing S.2161 (Bailey). This bill would establish a patient-centered Medication Assisted Treatment program for incarcerated individuals in jails and prisons. People would be able to opt into treatment at any point of their incarceration, receive treatment for the entirety of their incarceration, and work with clinical and parole personnel on a reentry strategy that includes access to treatment. It is important that the appropriate funding accompany this legislation, as part of the upcoming state budget.

Further, COMPA recommends that the State mandate access to Medication Assisted Treatment as part of its work release/parole programs. Under existing regulations, inmates may participate in an alcohol and substance abuse treatment program or other programs of rehabilitation. Since MAT is the recognized standard of care for opioid addiction, the regulations should specifically state that programs should connect individuals who fall into this category to treatment programs that utilize MAT.

In order to accomplish either of these goals, New York needs better data collection in correctional facilities to determine how many inmates suffer from Opioid Use Disorder.

Current data collection occurs only at intake and does not provide detailed information on the type of substance abuse disorder.

Lastly, when OTPs continue working with a patient who has been sent to the county jail through a guest dosing program, in some instances the OTP is not reimbursed for its services. This is because the patient comes off Medicaid when he or she enters the jail system and there is no overarching state policy that requires the county to pay for the services. This should be remedied, so OTPs can continue to effectively treat people in these instances.

- **Ensure access under New York’s Essential plan and Child Health Plus.** Both plans cover OTP services, but there is no mechanism for billing. This makes it impossible for OTPs to provide services to people and young adults under these plans. These patients deserve the same access as everyone else to MAT and OTP services and this should be corrected in the upcoming state budget.
- **Ensure Network Adequacy and access to treatment in commercial networks.** In order to ensure that all OTPs and DATA 2000 providers can participate in a Managed Care networks include an “any willing provider clause” for all commercial insurance plans.
- **Improve transportation options for Medicaid patients who receive services at OTPs.** Many patients rely on Medicaid transportation to access OTP services. **The initial processing delay** in receiving the necessary funds for this transportation results in hardship on patients without access to personal or public transportation, in both rural and urban areas have difficulty accessing OTP services. Getting Medicaid transportation (PTAR, etc.) started immediately is essential. Furthermore, Medicaid transportation can be inconsistent across the state. Patients report having missed appointments because their drivers have been late or may never show- up and the service is very costly to NY taxpayers. COMPA recommends looking at a model that relies on a service such as Uber Health instead of the current system. Uber Health is reliable and less costly. Patients would have immediate access to a ride and the state would have a cost-effective means of coordinating transportation for the people who need it.
- **Support the siting of OTPs in communities.** As we know, the opioid epidemic is everywhere and touches all of us. Access to OTP services is critical to avoiding overdoses and all the negative societal implications that come with addiction.

COMPA strongly opposes any legislation that unreasonably limits the siting of OTPs and other substance abuse clinics, such as A.8536 (Benedetto), which prohibits the approval of licenses for certain alcohol and substance abuse programs within five hundred feet of a school, public park, or church, synagogue, or other place of worship. We ask that the Task Force oppose this bill.

- **Oppose efforts to at the federal level to eliminate the waiver process for Buprenorphine.** Currently, doctors and other health care providers authorized to prescribe Buprenorphine for opioid addiction must apply for a federal waiver and receive training. Although COMPA strongly supports increasing access to Buprenorphine, we believe that certain protocols must be kept in place. Allowing for unfettered prescribing of Buprenorphine could lead to increased abuse of the drug and substandard treatment that does not provide

counseling and physical health services when needed. Further, health care providers are not fully taking advantage of this waiver process as it stands nor are they at capacity.

COMPA recommends developing a hub and spoke model similar to the model used in Vermont, where the OTP is the hub and the health care provider is this spoke. Under this approach, health care providers can rely on OTPs for patients that require more intensive treatment. Conversely, OTPS can refer more stabilized patients to doctors who will be able to prescribe them Buprenorphine as needed.

We encourage the Task Force to speak out against any proposal that completely allows unfettered prescribing of Buprenorphine.

- **Ensure access to Naloxone.** COMPA supports current state efforts through standing orders at pharmacies and the State's NCAP program to distribute Naloxone to people who are at risk of an overdose or who have loved ones at risk. We support S.5150-B (Harckham)/A.5603-B (Braunstein), which would require the co-prescribing of naloxone with opioid pain killers for people who are at a high risk of overdose based on criteria defined by the CDC. This includes people who have a substance abuse disorder, are receiving a high dosage of opioids, or who are also prescribed a benzodiazepine or non-benzodiazepine sedative hypnotics.



**APG Service Category: Medication Management Routine**

**Clinical Description**

Face- to -face visit with a prescribing professional for evaluation, monitoring, and management of prescribed medication. *(Methadone for treatment of OUD may only be prescribed in OTPs)*

Routine medication management involves the individual who has already been started on a medication and adjustment or monitoring of the medication needs to occur.

AND

2. patient sees nurse to return bottles and pick-up methadone for month. (Review and recommend policy options for dispensing by nurse by appointment)

**APG Service Category: Medication Administration and Observation**

**Clinical Description**

Administration or dispensing of a medicine via oral or non-oral route by a medical staff person appropriate to scope of practice, to be delivered in conjunction with observation of the individual prior to the administration and after as appropriate to the medication and individual condition.

There must be an order from a prescribing professional who meets state and federal requirements for the medications dispensed to an individual. Medical staff should determine any contraindications for the administration and observe individuals following administration as clinically indicated by the individual history, novelty of the medication, dosage changes and medical conditions that may affect individual response to the medication.

**Methadone Administration:**

- H0020 + KP modifier for first visit of the week

**Visits for stabilized patient for the month = Medication Mgmt. Routine + H0020 with KP modifier**



## Reimbursement Proposal

***Reinvest Medicare and SPA "HARP" dollars and reallocate proposed transportation savings to improve access and quality of treatment in OTPs.***

- 1. Establish Take-home Medication APG reimbursement rate for methadone and oral buprenorphine.**

A take-home reimbursement billed weekly would allow to account for costs associated with patients who meet the criteria to receive take-home medication of up to 4 weeks. We propose that programs an APG code be established which is equivalent to the first medication dispensed per week using the KP modifier (i.e., 2x the OTP daily dispensing rate for methadone, plus the unit cost for buprenorphine).

Historically, frequency of visits per week in OTP has remained constant at 4.3 visits per week. A take-home reimbursement will incentivize providers to provide take-home medication to eligible patients who can receive medication up to 4 weeks, thus **reducing transportation costs**. Take-home reimbursement can also be used for guest dosing to access treatment in non-OTP residential programs and can be used to help determine costs for treatment in correctional facilities.

- 2. Adjust OTP and CD-OP rates to provide equal access to qualified health professionals and support treatment infrastructure (see rate schedule comparison); eliminate need to admit in two separate NY outpatient licenses, maintaining 2 treatment plans. This is a more effective use of treatment staff and overall administrative savings. *Further savings should be considered from more effective/combined use of toxicology testing.***

- 3. Enhanced fees for integrated care, innovative models; including add-on code for higher credentialed direct service staff.**

#### **4. Proposed Model for Stabilized Methadone Patients in OTP- Medical Maintenance**

Stabilized methadone patients who meet criteria for medical maintenance  
eligible for 1 pick-up per month  
No assigned counselor

Separate program census

#### **Protocol:**

- 1. Patient has monthly scheduled appointment with prescribing professional**