



**Testimony of the New York Health Plan Association
to the**

**New York State Senate Joint Senate Task Force on Opioids, Addiction & Overdose
Prevention**

November 15, 2019

Introduction

The New York Health Plan Association (HPA), comprises 29 health plans that provide comprehensive health care services to more than eight million fully insured New Yorkers. We believe that every New Yorker deserves coverage for high-quality, affordable health care, and our member health plans are committed to continuing to work with state lawmakers, policymakers, and others to ensure and preserve affordability of health care. We appreciate the opportunity to offer testimony on efforts to end the opioid addiction crisis.

Health Plan Efforts to Address the Opioid Crisis

On behalf of the New York Health Plan Association (NYHPA), we thank you for your strong leadership and commitment to ending the opioid addiction crisis. Our members share your concerns and are committed to combatting the opioid crisis, taking a multi-pronged approach that treats addiction as a chronic illness and promotes prevention, evidence-based treatment, and education, to address this public health epidemic. For example, our member health plans have implemented a broad range of initiatives to ensure appropriate prescribing practices. This includes limits to the number of pills prescribed to help control access to both long- and short-acting opioids. In addition to quantity limits, several HPA member health plans have implemented so-called pharmacy "lock-in" programs that,

following identification by the health plan of a member that may be seeking to fill prescriptions by multiple providers at multiple pharmacies, lock the member into a single pharmacy for filling such prescriptions. Additionally, some plans have locked members into one prescriber for the writing of prescriptions as a way to eliminate "doctor shopping" and to alleviate multiple prescribers issuing multiple prescriptions to the same patient.

Our members are also working to encourage providers to prescribe opiates only when necessary and that there are other approaches that providers may wish to consider. Among them:

- Non-opioid prescription drugs;
- Referrals to pain management specialists;
- Behavioral health services, including counseling and therapy; and
- Physical and Occupational Therapy;

From the beginning of the opioid crisis, plans have worked to cover evidence-based treatment - both medication to treat addiction (Medication Assisted Treatment or MAT) and inpatient and outpatient treatment services - and have worked diligently to reduce barriers to appropriate treatment. Additionally, our member health plans have

implemented a variety of care management and intensive case management programs targeting members with behavioral health and substance abuse needs. These programs are designed to increase engagement in and adherence to treatment, aftercare and alternative levels of care to prevent unnecessary readmissions or relapses. The programs focus on creating individualized service plans that:

- Provide assistance with attendance at mental health, substance abuse and medical appointments;
- Support adherence to the member's treatment plan;
- Build and support links to peers and natural supports;
- Assist with obtaining benefits, housing, and community services;
- Provide education and assistance with skill building, recovery and rehabilitation;
- Develop crisis prevention plans; and
- Promote wellness and recovery.

Unintended Consequences of Current Statutory Requirements

While our member plans continue to develop and implement innovative strategies to deal with the opioid epidemic, it is critically important to focus on interventions that are evidence-based and have been shown to be effective for the treatment of opioid addiction. Likewise, it is essential for policymakers to examine statutory requirements

adopted over the past few years to evaluate the effectiveness of those changes before passing any additional treatment related legislation.

Since 2014, several new laws have been passed in an effort to address the crisis, with many provisions focused on treatment mandates.

In 2014, the state enacted Chapter 41 which implemented a series of aggressive reforms to combat heroin and opioid addiction, including; expanding insurance coverage for substance use disorder treatment; increasing access and enhancing treatment capacity across the state, including additional budget funding for expansions of opioid treatment and recovery services; and launching a public awareness and prevention campaign to inform New Yorkers about the dangers of heroin use and opioid misuse.

In 2016, additional legislation was passed (Chapters 69, 70 and 71), including measures to increase access to life-saving overdose reversal medication, regulations to limit opioid prescriptions from 30 to 7 days, and ongoing prevention education for all physicians and prescribers. Specifically, the 2016 legislation:

- Ended Prior Authorization for Inpatient Treatment *as Long as Such Treatment is Needed*: This legislation eliminated plans' ability to perform prior authorization for inpatient SUD treatment services for 14 days and precluded plans from performing concurrent utilization review until after 14 days. Those provisions

have now been extended to 28 days, with ability to perform concurrent review after 14 days.

- Ended Prior Authorization for Access to Medication Assisted Treatment (MAT).
- Required All Plans to Use State-Approved Criteria to Determine the Level of Care for Individuals Suffering from Substance Abuse - the LOCADTR tool.
- Mandated Insurance Coverage for Opioid Overdose-Reversal Medication.
- Increase Involuntary Commitment for Individuals Incapacitated by Substance Use Disorder from 48 to 72-Hours.
- Required Hospitals to Provide Follow-Up Treatment Service Options to Individuals Upon Hospital Discharge.
- Allowed More Trained Professionals to Administer Life-Saving Overdose-Reversal Medication.
- Expanded Wraparound Services to Support Long-Term Recovery - extends the wraparound program launched in 2014.
- Reduced Prescription Limits for Opioids from 30-days to Seven Days - with exceptions for chronic pain and other conditions.
- Required Ongoing Education on Addiction & Pain Management for All Physicians and Prescribers.
- Mandated Pharmacists Provide Easy to Understand Information on Risks Associated with Drug Addiction and Abuse.

- Required Data Collection on Overdoses and Prescriptions to Assist the State in Providing Additional Protections to Combat this Epidemic.

While well intentioned, based on data, we believe the prohibition on prior authorization for 14 days of inpatient treatment – now with the prohibition extended to 28 days – may have had unintended consequences which are not in the best interest of the member.

As outlined in an HPA Issue Brief from 2018, after the state began requiring coverage in 2016 for 14 days of inpatient treatment for substance use disorder without allowing prior or concurrent authorization by a plan, admissions data strongly suggested that provider behavior is influenced not by the patient's medical necessity for treatment, but instead by the providers' ability to keep a patient for 14 days. Specifically, for inpatient rehabilitation admissions, prior to the implementation of the 14-day stay statute, the average length of stay was fairly evenly distributed between seven, 14, 21 and 28 days. After implementation, the average length of stay shifted to just under 14 days.

The shift suggests that provider behavior is influenced by the elimination of the plans' ability to oversee the appropriateness of treatment. Since the average length of stay shifted to almost 13 days, the data suggest that providers are discharging patients just before they would be required to engage with the patient's health plan regarding

treatment progress and linkage to the most appropriate and least restrictive level of treatment. Further, data also showed an increase in the number of individuals with multiple admissions for inpatient detox services – including a 51% increase in the number of utilizers with 10 or more admissions for detox services. We have concerns these trends will continue – and possible become worse -- now that the inpatient requirement has been expanded to 28 days.

In order to ensure that individuals transitioning from one level of care to another receive the appropriate supports, the delivery system must be able to provide access to coordinated care that effectively transitions patients along the continuum of care. This will ensure that individuals get the necessary care in the most clinically appropriate setting, have a treatment plan in place, and have access to appropriate information regarding all medically necessary and available forms of treatment.

The current state budget included provisions requiring providers to engage in periodic consultation with health plans prior to the 14th day of inpatient treatment and that providers provide a written discharge plan with the patient and health plan. Health plan medical directors have access to the treatment history of the patient that is valuable information to have as part of the treatment planning process and information that the treating clinician may not have. It will be important that the state adopts

meaningful measures to ensure that providers abide by the requirement to engage with health plans to help patients transition from one level of treatment to another along the continuum of care and reduce the potential for readmission.

We also believe that it is critical to keep the following issues in mind:

- What is considered “appropriate treatment” is going to be different for every patient.
- “Need vs. Want,” the treatment a patient needs – is sometimes different than what they or their families might want. Residential treatment for 90 days vs. a 90 day combination of residential and community based treatment may be an example of wants vs. needs. As with the evolution of every other part of the healthcare delivery system, evidence based standards recommend that an efficient system of care should be individualized according to clinical need and addressed with the appropriate set of clinical services provided in **the least restrictive setting.**
- Patients/families say they have to “go through hoops” to access some treatment facilities. Some of this is related to the fact that there are some areas where treatment facilities/beds are in shorter supply (due in part to siting issues, people not wanting addiction clinics in their backyards). The Office of Alcohol and

Substance Abuse Services (OASAS) has developed a web portal to track bed availability.

Recommendations to Address the Opioid Crisis

As the Task Force considers efforts to combat the opioid crisis, any final recommendations should focus on measures that (1) support prevention, (2) ensure that treatment is based on evidence based guidelines, (3) promote measurement of outcomes to determine whether guidelines are being followed and care is effective, and (4) that individuals have access to the full spectrum of services and understand the options available to them. We would urge the Task Force to include the following recommendations:

Focus on Prevention

It is most critical for the state to focus on prevention and the quality of the care being provided. The state should support health plans' efforts around dosage limits for opioid prescribing, including allowing for prior authorization to ensure that there is an opportunity to discuss each case with the prescribing provider to weigh the benefits and risks.

Dosage Limits and Prior Authorization (PA):

- 50mg or less of Morphine Sulfate equivalent per day - exempt from PA process.

- PA required for anything over 50mg of Morphine Sulfate equivalent per day (at the option of the health plan).

For the treatment of new onset of acute pain (expected to last less than 8 weeks), the

Task Force should consider the following prescribing limits:

- Three-day supply for initial prescription for dental and emergency room discharge.
- Physicians may write longer prescription after documenting why more is needed and that non-opiate alternative is not appropriate.
- Limit of 60-day prescription following a surgical procedure for which the standard of care includes the use of opioids.

HPA supports an expansion of “lock-in” programs; where plans are able to help manage the care of members with a history of opioid use disorder by restricting them to seeing one prescriber and use one pharmacy. Authorization for lock-in should be provided to all government programs and the individual market. Such lock-in programs have been helpful in other states.

Regarding the state’s Prescription Management Program (PMP), or iSTOP:

- Health plans must have access to iSTOP – for plans to be able to have a complete picture of prescribed controlled medications they must have access to iSTOP; otherwise, they are unable to help reduce co-prescribing of opioids (two or more opioids from multiple providers) and intervene where there are potentially dangerous prescriptions of both an opioid and benzodiazepine, in real time by denying the prescription before a potential overdose occurs.
- Prescriptions written as part of discharge from an emergency room must be subject to iSTOP requirements. Emergency room and hospital practitioners who treat a patient with an opioid overdose to notify the patient's prescriber of the overdose, and any practitioner who administers an overdose reversal agent when treating a patient for an opioid overdose should report the event in the PMP within 72 hours of administration.
- DOH must inform physicians about their own treatment/prescribing patterns in comparison to peers. As part of such a program, DOH would outreach to prescribers to encourage them to align their prescribing practices with peers as follows:
 - First letter – “just to let you know”
 - Second letter – educational opportunities available
 - Third letter – request letter of explaining corrective plan within 14 days

- Fourth letter with accompanying phone call – if no action forthcoming
referral to Board or change of Provider Agreement

With respect to other prevention initiatives, HPA recommends that the state require information regarding prescription drug abuse and heroin that has already been developed by the state (see attached from www.combatheroin.ny.gov) to be sent to parents by public and private schools

Support Evidence Based Practice

Given our dedication to providing the best care for our members, we are committed to ensuring that evidence based treatment options are available. At the same time, we want to ensure that as our members access care within the system, they are supported with treatment options that have the greatest likelihood of success that meet their individual needs, and that they have clear treatment plans in place and a path towards recovery.

Prohibitions on prior authorization and other measures that restrict the ability of health plans to ensure that care is delivered in the most appropriate setting, and to conduct care management supports that help members navigate the system, help with follow-up care and other services that help the member succeed in recovery. Given these restrictions on health plans, it is critically important that providers recommend a level

of service that aligns with nationally-recognized, evidence-based standards that have been shown to be effective for the treatment of opioid addiction. Unfortunately, not all services are offered in all settings of care or are available at the time an individual needs such access. In order for opioid addiction treatment to be tailored at the individual level, all patients must have access to the full range of services.

To ensure access to evidence-based care, providers licensed to treat opioid addiction must be required to provide access to all forms of MAT. Providers that do not offer the full range of MAT should be required to coordinate access to such care with other facilities and should be required to inform patients and families about the availability of services and the extent to which facilities and programs are offering the full spectrum of services along the continuum of care.

Additional recommendations regarding evidence-based practice and providers include:

- Expand training requirements - no graduating medical resident in New York State should leave their residency program without having received DATA2000 training and have participated in MAT induction and treatment of a minimum number of patients with Opioid treatment needs. Such action could help improve access, decrease stigma and get training facilities to encourage faculty with needed expertise.

- Limit the ability of out of state providers to operate in NYS and solicit patients except where permitted by OASAS due to specific needs in state border areas.
Pulling people out of their community is detrimental to many and puts members out of reach of many protections promoted and instilled by NY DOH/OASAS.
- Establish a State Registry for all Waivered providers based on DEA list to simplify and streamline Network maintenance activities. License renewals, starting hospital jobs etc. would allow the State to solicit accurate and timely information of waivered providers

Improve Measurement of Treatment Outcomes

While the state is currently working with Shatterproof in the development of a rating system for addiction treatment programs, it will be critical that any final measures are meaningful, promote the use of evidence-based practices, and should be publicly reportable to help patients and their families understand the options available at each provider.

The state also should institute measures to enhance provider accountability. Approaches should include requiring treatment programs at all levels (inpatient and outpatient) to collect and report comprehensive quality assessment data, including treatment type, level of care, how individuals transition from one level to the next, and

outcomes so that the state can measure the system's success in treating opioid addiction and whether providers are reducing repeat detox and rehab visits. Providers should submit data specific to opioid addiction to the state on an annual basis for review of services provided and treatment outcomes. Further, OASAS should be directed to develop measures to track individuals through the treatment system.

Improving Access to Services

We likewise offer the following recommendations related to improve access to treatment options:

- Require all OASAS licensed/certified providers in New York state to use LOCADTR.
- Make information publicly available regarding whether a provider includes MAT as part of their treatment protocol.
- Authorize several pilot sites to test RN-led MAT models to perform comparative effectiveness analysis with the physician-led model in order to expand access to MAT.

CONCLUSION

HPA and its member plans recognize the impact opioid addiction is having on New Yorkers, their families and their communities, and are committed to ensuring that all

residents who need substance abuse treatment understand the options available to them and are able to get the care they need.

We appreciate the opportunity to offer our suggestions on measures to address the opioid crisis and look forward to continuing to work with members of the Senate Task Force on recommendations to improve access to services that will treat opioid addiction that are evidence based and promote clinically appropriate care.

