New York State Office of the Attorney General

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

Chairs: Senator Gustavo Rivera, Senator Pete Harckham, & Senator David Carlucci

Public Hearing on Strategies for Reducing Overdoses, Improving Individual Community Health, & Addressing the Harmful Consequences of Drug Use

October 3, 2019

Good morning Chairmen Rivera, Harckham and Carlucci, and members of the task force. My name is Jill Faber, and I am the Deputy Attorney General for Regional Affairs in the Office of New York State Attorney General Letitia James. Thank you all for allowing me the opportunity to share testimony on behalf of our office today.

We are in the midst of a national public health crisis – the opioid epidemic – and thus this hearing is of critical importance to all Americans, and certainly to New Yorkers. Every county across our great state is struggling with the challenges of widespread substance use disorders. It is said that 60-percent of the population in our jails and prisons are there as a direct consequence of some aspect of this crisis. Our hospital emergency departments are straining under the pressure of New Yorkers arriving with opioid use disorders—tens of thousands annually. Cities like Syracuse, New York, have had to add staff to their morgues to assist with the body count of New Yorkers felled by this disease. And it is important to recognize that these people in crisis – in our prisons, in our hospitals, and in our morgues – only reflect the people that have been hit hardest. They are the tip of the human iceberg struggling with use disorders. And like seeing the tip of an iceberg, we must recognize that there is a massive number of ill people just below the surface.

As many in this room today know, the Attorney General has taken vigorous action to hold accountable the drug manufacturers and distributors whose irresponsible conduct gave rise to the opioid epidemic. Our office is leading the litigation against culpable manufacturers and distributors, and we are collaborating closely with the counties and local government units that have also brought suit against these companies. Both at the state and national levels, Attorney General James is aggressively pressing the litigation effort forward to uncover exactly what happened, make those responsible pay to help clean it up, and ensure that the reckless profit-

seeking that caused this problem is never again allowed to create such a painful and deep public health crisis.

I also want to address our office's recent decision not to join in the settlement with Purdue Pharma and the Sackler family in the bellwether litigation in Ohio. Our decision not to accept the settlement reflects our office's desire to hold Purdue and the Sackler family accountable for their actions. Attorney General James, along with other attorneys general who declined to join the settlement, believes that the terms of the settlement do not cause Purdue or the Sacklers to take any responsibility whatsoever for their actions, nor does it require them to give back the ill-gotten gains that they earned from their nefarious and unlawful conduct. The money included in the deal is derived from the sale of a Purdue subsidiary and future sales of the company's opioids, creating the perverse dynamic of funding the relief by selling more opioids. And perhaps most disturbingly, under the settlement, the Sacklers and Purdue would not be required to acknowledge any wrongdoing for the crisis that they so clearly caused. This is both immoral and unacceptable.

Apart from our litigation, the Attorney General's Office is informed on this issue by our engagement with the public and with professions interfacing with victims of the opioid crisis. Over the past several months, Attorney General James has convened roundtable events across the state where she spent hours with people in recovery, community leaders, advocates, impacted families, law enforcement officials, medical providers and others, to hear and learn about their challenges.

Our Health Care Bureau, similarly reaches out to patient advocates, community groups and providers, and we have a consumer complaint line that addresses individual consumer complaints about health care—often about health plan coverage, including coverage of and access to treatment. Here's just some of what we have learned through these various interactions:

1. People struggling with use disorders are winding up in the criminal justice system rather than getting access to evidence-based treatment;
2. Despite the best doctors in the world, and state-of-the-art medical facilities, New Yorkers suffering from opioid use disorder do not have easy access to confidential, evidence-based treatment, namely medication based treatment (MBT), including buprenorphine;
3. Treatment for opioid use disorder is straightforward, and it can be lifesaving, family-saving, job-saving, and system-saving; and
4. People get better – people live – if they are treated.

One significant way our office has addressed *access to treatment* is though our Health Care Bureau's work in making health plans adhere to mental health parity laws, ensuring that health plans cover treatment for opioid use disorder and other mental health issues. For example, NYAG investigated and ultimately entered into settlements with seven major health plans that required plans to implement sweeping reforms in their administration of behavioral health benefits, in particular relating to medical management practices, coverage of residential treatment, and co-pays for outpatient treatment, and to submit regular compliance reports. Two settlements in particular addressed the improper and onerous imposition of preauthorization requirements for medication based treatment (MBT), and successfully eliminated preauthorization for MBT in two national plans—Cigna and Anthem.

All that said, our office has deep concerns that we need to do more *now* and that our priority as a state should be to ensure that people struggling with opioid use disorder are able to get the necessary treatment they need. We are concerned that given the numbers of those struggling with

use disorders, there may not be sufficient capacity in our state to treat all of those who need treatment.

Given this reality, we are looking at different avenues that would open up opportunities for treatment. As mentioned earlier, our office has been successful in getting major health plans to eliminate preauthorization requirements for medication based treatment; we applaud the legislature for wisely passing legislation that would require this for all plans operating in New York and we look forward to the legislation being signed into law. But while health plans will now hopefully not interfere with health providers providing medication based treatment to their patients, our office wants to make sure that there are adequate numbers of providers to offer the medication based treatment, including buprenorphine,[1] that providers can make available in their offices.

Our findings on this front paint a problematic picture: through public data, we have found that out of about 215,000 eligible healthcare providers in New York State – which includes physicians, nurse practitioners, and physician's assistants—only roughly 7,200 hold the waiver to prescribe buprenorphine. That's 3.2% of eligible providers. Of these 3.2% of prescribers who hold the waiver, we know that many never actually *use* it to prescribe the medication.

To at least partially address this issue, and open up the provider pipeline, this summer, Attorney General James joined with 38 other Attorneys General in signing a letter to Congress to advocate for elimination of the waiver requirement that demands an 8-hour course in order to provide buprenorphine with the hopes that more providers will be willing to make medication based treatment available in their offices.

At the same time, the Attorney General conducted a treatment capacity survey of hospitals across the state to determine how our emergency departments are prepared to provide medication based treatment to the most severe presentations of this illness. The results of this survey are troubling. It shows that almost half of the surveyed hospitals have no "waivered" providers in the emergency room able to write prescriptions for medication based treatment. This means that a patient who presents to an ER with an overdose would not – in these hospitals – be able to depart from the hospital with the medicine needed to begin to treat their opioid use disorder.

The hospitals that had no providers with the waiver collectively reported seeing more than 9,000 patients with OUD annually. That is 9,000 patients in a single year who required emergency medical intervention for a fatal illness from a medical facility that was unable to prescribe a first-line medication for treatment.

In our conversations with stakeholders throughout the state, we heard about the importance of other factors in ensuring effective treatment. As important as the emergency department is in

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[1] Buprenorphine, of course, is not the only treatment drug, but it is the most readily-deployable in the medical community at large. The Attorney General is not endorsing one approach, but at this moment in time, it is the only evidence-based, FDA approved treatment available immediately in an office-setting with demonstrated results. The availability of medical providers certified to prescribe buprenorphine is vital for a number of reasons: 1. It allows treatment to begin without detoxing a patient—a tortuous experience; 2. It allows a patient to think more clearly right away, and assist in bridging them to long-term primary care; 3. It is able to be administered in any practitioner's office; and 4. It keeps people alive.

administering initial treatment, that treatment needs to be an effective bridge *into* evidence-based, medical care with care available *after* the emergency room. Many stakeholders also identified the lack of safe, stable housing as a barrier to recovery. Without secure housing, the likelihood that individuals will relapse is very high. Advocates touted the efficacy of pairing individuals going through treatment with "recovery partners" who provide intensive social, emotional support and guidance. Programs that provide this type of support service were identified as particularly successful.

One other area of note that merits mentioning is the role of our jails in addressing this crisis. In our efforts to help people suffering from use disorders, New Yorkers, and Americans alike, have leaned disproportionately on jails and prisons to try to keep these victims safe. But this simply isn't enough, as evidenced by the record-breaking death tolls. Just as we must treat victims in emergency departments, we must also provide treatment in our jails. An excellent example can be found in Rhode Island, where that state launched a medical program in the prisons. The approach was simple: the medical staff in the prisons screened each and every person incarcerated for OUD. If OUD was identified, the individual would be provided with an FDA-approved treatment medication. When the time came to re-integrate the individual to the community, the state bridged that individual safely to a medical care provider where that care could continue uninterrupted. The result, in less than a year's time, was a decrease in death rates for that vulnerable population by 60%. The impact on the overall state death toll for OUD was a reduction of 12%.

Time and again, we have heard from desperate families across the state, all with similar stories. With no available treatment options, a person in the throes of severe OUD may end up in jail—either coincidentally or deliberately placed there by family. They may then end up in drug court, where they are assigned to attend an opioid treatment clinic (that may or may not have an opening), or a detoxification facility that does not provide evidence-based treatment or that has a waiting list longer than that person can afford to wait. Neither of these paths will provide them the health care OUD demands. Moreover, neither of these are viable for the unseen population of sufferers who have not yet overdosed, but who desperately need help. The patchwork of resources that communities have put together does little for the worker, afraid they will lose their job if they are "outed" for this illness. It does nothing for the mom or dad trying abstinence from drugs in the face of insurmountable odds, knowing their doctor isn't willing or prepared to treat them properly and afraid standing in line at a clinic will lead to the loss of their kids.

Given the enormous numbers of New Yorkers suffering with OUD, medical providers should be fully engaged, prepared, and willing to provide treatment. Hospitals, with emergency departments where patients experiencing an overdose are admitted, should be able to offer evidence-based medical treatment for these patients, in much the same way hospitals treat people with other chronic conditions. Of course, it is also crucial to support harm reduction programs including naloxone distribution and to make sure that we as a state have supports for long-term recovery—including supportive housing and employment.

On behalf of Attorney General James, I again thank the task force for the opportunity to be heard on this vital issue. She believes that non-stigmatizing, integrated medical care is essential to saving the lives of vulnerable New Yorkers, and appreciates the chance to discuss these issues with you today.