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News for policy and program decision-makers

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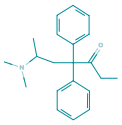
In This Issue...



OPIOID TREATMENT PROGRAMS

One-stop shopping: What integrated care means to CODAC and its OTP

The American Association for the Treatment of Opioid Dependence (AATOD) is an association of, mainly, opioid treatment programs (OTPS), the only providers in the United States who can legally treat opioid use disorder (OUD) with maintenance methadone. AATOD met last week in Philadelphia for its meeting which occurs every 18 months. This meeting's them was "The evolving field of opioid treatment."

A highlight of the meeting was a presentation by Linda Hurley, president/CEO of CODAC Behavioral Healthcare, on "one-stop shopping."

Bottom Line...
At the AATOD meeting in Philadelphia last week, Linda Hurley described how the CODAC OTP has integrated primary care and much else into treatment, and how this integration of care can include many services not considered treatment at all, but just what the individual needs.

Hurley has brought "integrated care," a buzzword that is often used but rarely practiced, into reality. "You can't have functional health and wellness if we don't look at the whole

See **CODAC** page 2

Agreement on overdose reversal drug leads to pledge not to market Opvee

Just over two years after the Food and Drug Administration (FDA) characterized a newly approved prescription nasal spray as an important opioid overdose reversal option for use by first responders and harm reduction groups (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.34062) , a legal settlement involving the manufacturer and New York state appears to have permanently derailed the marketing of the drug.

Bottom Line...
New York state officials pursued an investigation of pharmaceutical manufacturer Indivior, Inc., over company marketing practices that suggested its opioid overdose reversal drug was interchangeable with the more widely used naloxone.

New York Attorney General Letitia James on Sept. 30 announced that a settlement had been reached with pharmaceutical company Indivior, Inc., maker of the nalmefene hydrochloride nasal spray that has been sold as Opvee. New York officials had accused Indivior of marketing Opvee as interchangeable with naloxone for overdose reversal, even though health officials and harm reduction advocates have warned that Opvee's longer-acting effects can result in severe and prolonged withdrawal symptoms.

Under the settlement, Indivior must refund monies paid by government agencies for Opvee, recall improperly sold doses and reform company marketing and training practices, according to James' office. The Attorney General stated last month that Indivior

See **Opvee** page 4

CODAC FROM PAGE 1

picture," she said at the October 7 workshop.

Integrated care means coordinating methods and models across:

- Funding
- Electronic health record – communication
- Administration
- Organization
- Service Delivery
- Clinical levels

Collaborating between cure and care

The purpose of this integration is to "build connectivity, alignment, and collaboration between the cure and care sectors," said Hurley. The goals are to:

- Improve quality of care
- Enhance quality of life
- Increase consumer satisfaction
- Boost system efficiency

The first step, for an OTP, is to integrate primary care, said Hurley.

It may sound easy, but it's complex. Breaking down the frameworks can help.

There are two types of integration:

- Horizontal integration is focused on a demographic and links health, social, and care providers through teams or networks to support specific groups (one such group is people with OUD)
- Vertical integration is focused on sectors and connects services across all care levels (primary, community, hospital, tertiary) using best-practice pathways or smooth care transitions, and is based on a single sector (such as OTPs)

It's important to focus on the person, not the demographic, and not the provider – that is the point of integration, said Hurley. But this is "changing the culture of care."

For example, when someone comes to CODAC, "we don't say 'we know what you need, let us help you,'" said Hurley. "We ask, 'Are you hungry? Do you need food?' And we'll take care of that. When they have enough courage to come to us [for treatment], we will be there." It's not just a matter of earning trust – it's practical. Someone with an OUD doesn't just need medication.

"If I am an opioid treatment provider and you come to me for care, one of the ways I provide integrated treatment is I can give you bus passes," said Hurley.

Hurley recalled a patient who was experiencing extreme anxiety waiting for his methadone at a window – it was not only the medication, but that he needed to report to probation and that he didn't have his Medicaid information updated. "He was starting to get worked up, to get loud," said Hurley. "We have six dosing windows, but they're not always all open. We were able to get him his medicine in 3 minutes. Then the peer recovery support specialist took him down the hall to his probation officer. And then, because he didn't have his documentation for continued Medicaid, we took him down the other hall to the Medicaid office. He went from highly anxious – not well – to sitting calmly with a glass of water," she said.

Services provided

Below are the medical services provided by CODAC as part of integrated care:

- Primary Care
- Infectious Disease: inclusive of but not limited to Hepatitis C, HIV, Sexually Transmitted Disease (STI), Syphilis
- Reproductive Health: Gender Specific
- Obstetrics
- Identity Affirming Care
- Healthy Aging
- Pain Management
- Dentistry
- Audiology
- Podiatry
- Treatment of opioid use disorder
- Treatment of alcohol use disorder
- Treatment of stimulant use disorder
- Treatment of all other use disorder

All FDA-approved medications for treatment of all substance use disorders are utilized.

ALCOHOLISM & DRUG ABUSE WEEKLY
News for policy and program decision-makers

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Below are the mental health services provided as part of integrated care:

- Psychiatry
- Psychology
- Behavioral Health
- Tobacco Cessation Services
- Health Home Services
- Telehealth Services
- Problem Gambling Services

Below are the critical social service collaborations provided as part of integrated care:

- Wellness/exercise groups
- Housing
- Transportation
- Meeting and training space for the community
- Career path development
- Food and housing stability
- Nutrition education
- Income tax assistance
- Health insurance navigation
- Heating and utility assistance
- Home Safety education and assistance
- Acupuncture
- Yoga
- Tai Chi
- Balance and agility training

Practicalities

CODAC has the benefit of operating in the small state of Rhode Island, where the bureaucracy isn't as cumbersome as in, say, New York. It also has the benefit of support from the state government, which can help with the integration of many state services, including probation and parole, child services, Medicaid, SNAP, WIC, and more.

There is a critical mass as far as patient census before other organizations, such as the state, will come into the building, said Hurley, responding to a question from the audience. "It will be community-specific," she said. "We guaranteed 350. And we're marketing to the whole community, not just the OTP, so the partner will have access to a primarily Medicaid population with high need. We're also going to let the neighborhood know you're here." The state wants to get more people healthy, so wants to get more into Medicaid.

CODAC's building is large enough to be able to provide many services under one roof. Hurley acknowledged that most OTPs are in smaller facilities which couldn't do what CODAC does logistically. "But we have to make this integration more efficient."

Coordination and collaboration can be difficult when various sectors are fighting over the same shrinking pie of funding. Many hospitals, Federally Qualified Health Centers, and Certified Community Behavioral Health Clinics (CCBHCs) have created services for buprenorphine, Hurley noted. "Suddenly every CCBHC is an expert in opioid treatment, and because they financially need to have that service, they will not refer" patients to an OTP.

CCBHCs are funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), or Medicaid.

Only OTPs can prescribe and dispense methadone for OUD, so it's natural that Hurley's integration of care begins with methadone and the OTP.

Income opportunities

Hurley is aware of the financial pressures on OTPs. One of the ways CODAC makes money is by renting space, to Brown University, to the University of Massachusetts Chan Medical School.

She asked for a show of hands of how many attendees work in a Medicaid-funded system. Most of the attendees raised their hands. In January 2027, this Medicaid money will most likely go away, thanks to H.R. 1. "We're going to need to think about how we continue to provide care," said Hurley. "We need to be creative. What do you offer? Can you sell trainings?"

Certainly, OTPs, the experts in treating OUD, can train other providers.

"Twenty-five years ago, we would say 'Keep your heads down, don't make any noise,'" said Hurley. "With the opioid epidemic, it was time for us to say 'We're the experts, we know how to do this.' We aren't used to bragging, but everyone here [at AATOD] is an expert. We know what this disease is. So sell your trainings."

There are many things OTPs can do that others can't, said Hurley. For example, motivational interviewing is a key counseling skill.

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Linda Hurley

Also present within CODAC – training by the Department of Labor. When the new work documentation requirements for Medicaid kick in, "we will know right away what they are," said CODAC. And it's important for OTPs to know what these are, so they can keep their patients enrolled in Medicaid – and keep getting paid. "'As soon as anything happens we can provide these forms for you,'" CODAC tells patients, she said. "Our goal is to do this in all eight sites, because it's going to happen," she said of Medicaid cuts.

It's the same with managed care Medicaid organizations, said Hurley, noting that they want to keep patients enrolled as well. They don't want to lose any of their premiums.

Mobile units are another way of creating revenue, said Hurley. "We are getting new patients for whom we can bill, who normally would not be coming into our building, and at the same time, we are able to take care into the community, which is critical." •

Opvee from page 1
has informed interested parties that it will "discontinue promotion of Opvee altogether."

"The most effective and reliable opioid overdose reversal medication on the market remains the 4-mg naloxone, which is the only antagonist covered under the state's standing order," James McDonald, commissioner of the New York State Department of Health, said in last month's announcement of the settlement with Indivior.

Stakeholders have credited James for pursuing the state's action. A former general counsel for the New York Office of Addiction Services and Supports (OASAS) told ADAW that he hopes government jurisdictions nationally will begin to examine more closely the variety of overdose reversal options that have emerged, rather than simply seeing 4-mg brand-name Narcan as the only answer.

"New York has historically bought only Narcan," said Rob Kent, president of Kent Strategic Advisors, LLC. "It should be getting better prices to buy more [naloxone]."

Targets in marketing practices

According to the New York Attorney General's office, an investigation uncovered that although the state had not authorized use of Opvee in programs using non-medical personnel such as first responders or community health workers, representatives from Indivior had promoted Opvee to local officials ranging from county sheriffs to directors of emergency medical services.

In one instance, a county sheriff's office wrote a standing order for Opvee on the advice of the manufacturer, after state health officials had told the sheriff's office that the drug was not approved for non-prescription use or for use with a standing order. Last April, the sheriff's office reached a settlement with the state and vowed only to use authorized overdose reversal drugs in the future; the office had previously spent $22,500 on Opvee.

The Sept. 30 statement from the Attorney General's office reads in part, "Not only does Opvee not improve survival rates or patient outcomes, but its longer duration can also cause severe and prolonged withdrawal symptoms, lasting up to 12 hours compared to Narcan's typical 90 minutes. This extended withdrawal is painful for patients and puts them at risk of life-threatening conditions for longer than necessary. The American College of Medical Toxicology (ACMT) and American Academy of Clinical Toxicology (AACT)have cautioned that replacing Narcan with Opvee for first responders could cause unnecessary harm without providing any added benefit."

"Not only does Opvee not improve survival rates or patient outcomes, but its longer duration can also cause severe and prolonged withdrawal symptoms, lasting up to 12 hours compared to Narcan's typical 90 minutes. This extended withdrawal is painful for patients and puts them at risk of life- threatening conditions for longer than necessary."

NY AG Letitia James

Kent said that if nalmefene was being promoted as equivalent to naloxone, that amounted to adding confusion around a topic already replete with misinformation. Much of the discussion around overdose reversal drugs is "tilted to a point of view," he said.

ADAW asked spokespersons for Indivior to comment on the settlement and any future plans for nalmefene, but they did not offer any responses by press time. It remains unclear as to where and to what extent communities across the country are still using Opvee for overdose reversal.

FDA's outlook in 2023

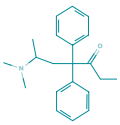
The FDA had granted priority review to the application for Opvee and approved the nalmefene nasal spray in May 2023. Then-FDA Commissioner Robert Califf, M.D., said at the time of the approval, "On the heels of the FDA's recent approval of the first over-the-counter opioid reversal agent, the availability of nalmefene nasal spray places a new prescription overdose reversal option in the hands of communities, harm reduction groups and emergency responders."

National harm reduction advocates have since characterized higher-dose reversal medications as unnecessary at best and potentially dangerous if they force individuals experiencing withdrawal to turn to other drug use.

Kent said that while New York officials deserve credit for targeting any misleading marketing efforts, he would like to see jurisdictions across the country re-examine any of their traditional notions about overdose reversal drugs. The emergence of generic versions of naloxone, as well as alternatives in dosage strength, calls for a broader approach in acquiring medication that is sorely needed in communities, he said.

"At OASAS in 2016 we made an effort to increase access to nasal naloxone. Nasal Narcan was the only drug available at the time," Kent said. "Now there are generics and other doses. But people settle back on what's been done in the past."

He added, "If you make companies compete, they'll offer the best price they can." Kent hopes the settlement with Indivior doesn't simply lead to less access to overdose reversal agents overall. "There's never going to be enough," he said. •



OPIOID TREATMENT PROGRAMS

New York coalition of OTPs focus on the needs of the field going forward

The Coalition of Medication-Assisted Treatment Providers and Advocates (COMPA) issues is policy and budget agenda last month. As a coalition of opioid treatment programs (OTPs) and other providers in New York, COMPA's direction forward is always a guide for the rest of the country. COMPA led the way to getting reimbursement for OTPs providing take-homes (typically, reimbursement is only provided on the day a patient shows up). COMPA also provided crucial insights into how to provide methadone treatment early on in COVID. So the agenda for the coming months is important.

New York is still in the midst of an opioid epidemic despite modest improvements in the number of fatalities, and the numbers of reversed overdoses remains high. More than 6,300 New Yorkers died from overdoses in 2024. Overdose death rates among Black and Latino New Yorkers increased by 17% and 11%. In New York City alone, one individual dies every four hours from a drug overdose.

So the overdose crisis is not over.

There are 126 OTPs in New York, serving more than 54,000 patients. Only 35 counties in this large state of 62 counties have an OTP.

Below are COMPA recommendations to deal with the epidemic.

Medicaid

Given that the provisions of H.R.1 will disrupt the successful system reforms that New York state has implemented to achieve continuous enrollment and appropriate exemptions from Medicaid work requirement, COMPA urges the state to: 1) make investments that support eligibility determination at both the provider and the local government unit level, and 2) ensure work requirement exemptions are in place for New Yorkers with substance use disorder (SUD).

New York began carving in behavioral health services into the state's Medicaid managed care program in 2015. Since that time, managed care plans have been found to violate state laws, regulations, and contract provisions while New Yorkers with serious behavioral health conditions wait to obtain care from community-based providers that have none of the sophisticated billing and claims departments that hospital systems have. By enacting A.8055(Simon)/S.8309 (Brouk), COMPA believes the state will save hundreds of millions of dollars, including the portion state funds which MCOs can retain for profit and administrative funds (minimum of 11%). Instead, those funds should be redirected to rates, care, and treatment expansion.

COMPA recommends imposing high penalties on MCOs that make incorrect Medicaid payments to deter such practices.

COMPA urges reinvesting the annual Medicaid MCO underspend in behavioral health services. A report from the DOH found that "Even with insufficient provider networks, Medicaid Managed Care Organizations (MCOs) are not spending all their allotted premiums on behavioral health services. A review of two MCO funding mechanisms, the Behavioral Health Expenditure Target (BHET), and Medicaid Loss Ratio (MLR) recoveries—shows that MCOs remitted over $220 million in allocated premiums back to the state from 2017 to 2020. This includes $91 million in BHET remittances from 2018 to 2020 and $130 million in MLR remittances from 2017 to 2019." For these reasons, the Medicaid MCO underspend should be reinvested in behavioral health services.

Despite attacks on Medicaid eligibility the Trump Administration has allowed physician fee schedule and other reimbursement increases to go into effect. For this reason, COMPA urges the Executive to include an inflationary factor adjustment for outpatient Medicaid rates to offset the high inflationary costs of employers, including well-publicized utility and health insurance costs, and the inflationary costs on employees for groceries, utilities, and health insurance. Retaining the existing workforce will rely heavily on being able to adjust wages to offset some inflationary costs on workers.

COMPA urges that providers be protected against federal Medicaid policy changes that will increase the uninsured. Adjust vital access provider and indigent care pool policies to capture the cycling on and off Medicaid that will ruin outpatient providers revenue cycle plans as eligibility determinations and look back policies conform with new federal rules. Make modest state-only investments into pools for OASAS providers to help offset billing losses.

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Integrated Care

To gain fiscal efficiencies by treating dual-diagnosed patients in one setting, COMPA recommends establishing an add-on rate for services provided by higher-credentialed, licensed mental health practitioners. COMPA supports more treatment of dual-diagnosed individuals at SUD programs and the provision of primary health care in appropriate licensed settings. Currently, there is a group therapy rate add-on when a social worker or licensed mental health practitioner staffs group therapy sessions, but there is not equivalent rate add-on for the diagnosis or assessment-based treatment planning sessions that determine whether an individual should receive treatment in a group setting. Further, to fully support the integration of comprehensive services, COMPA recommends establishing rates for OTPs to serve as the primary care provider.

OTPs serve some of the highest cost Medicaid recipients who suffer from co-morbid physical health conditions and chronic illness. OTPs are perfectly situated to serve as the primary care provider to these patients, since they see these individuals sometimes daily. Several years ago, the State removed regulatory barriers to this end. However, a fiscally sound and sustainable reimbursement rate is needed to support the delivery of integrated behavioral health and primary care. The State should require Medicaid managed care organizations to integrate primary care for enrolled OTP patients. Preventative services would include screenings, vaccinations, necessary ancillary services, and these services would be reimbursed through specifically designed chronic care bundles using published facility APG rates.

Other issues

Stigma and siting. COMPA supports efforts to help communities and providers decide where programs should be sited but believes that more education and coordination is necessary. We

FROM THE FIELD

Indifference

By Rob Kent, Esq.

"Indifference is not a response. Indifference is not a beginning; it is an end. And, therefore, indifference is always the friend of the enemy, for it benefits the aggressor -- never the victim, whose pain is magnified when he or she feels forgotten." -- Elie Wiesel

At best, government on every level is indifferent to taking the actions necessary to make it possible for more folks to find recovery from drug and alcohol addiction! The indifference is bipartisan!

It is frustrating that I cannot tell you why government is indifferent! Investing in addiction prevention, treatment, and recovery is one of the smartest economic investments that government can make! Preventing addiction makes fiscal sense! Treating addiction makes economic sense! Investing in recovery services and supports make economic sense! Folks who find recovery work, pay taxes, buy homes - they contribute to our economy!

Helping folks avoid addiction or find recovery is morally correct! It is one of the best examples of serving others and it is a wonderful human equation in that it pays compound interest as those who find recovery pay it forward to those trying to find it and they do it as well!

Sometimes you cannot win with all sides! Some believe that folks can just stop using drugs and alcohol if they really want to! Some never forget past mistakes made in the response drug use! It is a moral failing and an economic mistake to not invest in addiction prevention, treatment, and recovery services and supports.

Indifference has been a problem with many other situations and history shows us that indifference has been a contributing factor to most of the awful things humans have done to each other!

The best way to fight indifference is to either work to change the views of the disinterested or to find different folks who are not indifferent!

I will be guided by the words of Beth Macy, the author of "Dopesick" and "Raising Lazarus" who wrote: "Everywhere in America, it was painstaking to walk skeptics through the social, criminal, and medical benefits of helping the least of their brethren, but worth it—even if you had to get your a** kicked."

Please do not take the words above as a sign that I am defeated or have given up! Quite the opposite! I will take both approaches to fighting indifference and I hope you will as well! It is well worth it! •

Rob Kent, Esq., is president of Kent Strategic Advisors. He is formerly general counsel for the White House of Office of National Drug Control Policy, and the New York State Office of Addiction Services and Supports. Reach him at www.Kentstrategicadvisors.com

ask the Executive to fund a comprehensive plan that includes 1) a public service campaign on the importance of treatment to community wellbeing, with an emphasis on methadone treatment and 2) includes town hall meetings that engage and inform stakeholders about the siting process.

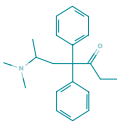
Involuntary commitment. While COMPA opposes involuntary commitment for addiction treatment, it is essential to maintain, improve, and expand viable options to enter treatment. A robust statewide reform of mandated treatment, such as that which is offered in drug courts' alternatives to incarceration, is needed.

Workforce: As inflation hits all sectors of the economy, the impact on workers in the community substance use is combined by low wages and high personal expenses due to inflation. The federal consumer price index (CPI) for July was 2.7% with public promises that the factor will rise through the end of 2025. In the past, the July CPI factor was used to determine the human services cost of living adjustment to rates and contracts. This year, to retain workers and address staff vacancies, including a cost-of-living adjustment, must be included in the Executive Budget proposal.

DEA 72 hour rule: COMPA urges the Governor to sign and quickly implement S.3416-C/A.5892-A to save lives. The bill aligns New York state law with the federal Drug Enforcement Agency's rule that allows for a 3-day supply of medication (methadone or buprenorphine) to opioid overdose patients when they are transitioning to treatment. New York's law allowed this in ERs in hospitals without full-time pharmacies. The bill opens this up to all institutional dispensers and practitioners and is like the Governor's recommendation in Part O of S.3007/A.3007 (Executive Budget proposal).

OMIG audits: COMPA supports passage of S.4955-A (Harckham)/A.1069-A (Paulin), which would reform the Medicaid audit process of the OMIG. The current process is focused on meeting a pre-determined fiscal target at the expense of providers who have not engaged in fraud or abuse. This aggressive approach threatens to destabilize the OTP system and has already resulted in the loss of one program that served 1,500 patients.

Overdose prevention sites S.399-B(Rivera) and A.338-A (Rosenthal): COMPA supports this policy as an important part of harm reduction efforts if it is accompanied by protocols to establish connections to treatment. Evidence shows that these programs prevent overdose deaths and play a critical role in combatting the opioid epidemic. •



OPIOID TREATMENT PROGRAMS

Reaction to new regulations: "Culture change" a challenge for OTPs

The new regulations governing opioid treatment programs (OTPs) took effect a year ago; some states are still coming into compliance with all of them. At the AATOD meeting in Philadelphia last week, stakeholders at an invitation-only policy luncheon (ADAW was invited) described their responses to the liberalized OTP regulations, announced in February 2024 (see https://onlinelibrary.wiley.com/doi/10.1002/adaw.34023).

The host of the luncheon, AATOD president Mark Parrino, started off the revealing commentary. AATOD board members from various states were called on, as were the State Opioid Treatment Authorities (SOTAs). SOTAs are members of the National Association of State Alcohol and Drug Agency Directors (NASADAD), and are responsible, among other things, for helping OTPs in their state comply with federal regulations.

Yngvild Olsen, M.D., former director of the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA), shepherded the new regulations through. She opened the discussion at the policy luncheon, at Parrino's invitation. Widely hailed for her meticulous attention to the rulemaking process and the regulatory quality of the final product, Olsen, who has experience working in an OTP, knew what needed to be done. Methadone needed to be easier to access, and OTPs needed to be freed from their constraints in trying to provide patient-centered care. And it was, after all, OTPs and Parrino who wanted these changes.

However, it appears that it is providers – OTPs – which are the slowest to change, with the reason often explained as the "clinical culture."

Among the changes:

- Induction doses could be higher than previously
- More liberal take-homes, based on clinical judgement rather than a strict rule
- Elimination of the one-year requirement of a diagnosed opioid use disorder (OUD) for admission to an OTP
- A clarification that methadone must not be withheld from a patient who refuses counseling

The take-home issue and the counseling issue both are still facing considerable glitches in terms of compliance. Basically, take-homes can now be given to patients who are less than stable. This is a holdover from COVID, when the take-home flexibility was made temporary. The final rule makes that flexibility permanent, but some OTPs still are not sure they want to go that far. As for counseling, there

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is a lot of confusion. All the rule says is that an OTP can't refuse to dose a patient just because the patient doesn't want to see a counselor – that is a kind of blackmail that is unacceptable. But it doesn't eliminate the requirement that counseling be accessible. Olsen reported that there is indeed hesitancy about the rule that separates counseling from medication access. The general dispute was that some programs felt that they no longer needed to provide counseling at all, and some thought they could even just fire counselors. That would save money, but it would not be good treatment. "You have to work on how to engage people in counseling," said Olsen.

We are not identifying the specific board members and SOTAs, but just recounting the overall perceptions of how well the new regulations are being implemented.

All the rule says is that an OTP can't refuse to dose a patient just because the patient doesn't want to see a counselor – that is a kind of blackmail that is unacceptable. But it doesn't eliminate the requirement that counseling be accessible.

SOTA and AATOD responses

SOTA: "We're focused on patient-centered care. More people are entering care because of these new regulations. Most programs have aligned with them. Counseling still needs to be addressed.

AATOD: "We don't see any negative potential [to the new regulations]. Nowhere does it say no counseling is required. Now our process has to be on how to motivate individuals."

AATOD: "We had the strong support of our SOTA. But this is on the providers. They were early adopters of eliminating the one-year rule, and about induction doses. But they were used to doing things the old way in terms of take-homes."

AATOD: "We have two other state agencies that have oversight over OTPs. The SOTA aligned right away. But there are still issues with mandatory counseling. Eliminating the one-year rule and raising the induction dose went well. But the biggest challenge is changing the clinical culture of the OTPs. We did not see a big jump in take-home doses. They also said 'We can't increase the dose that quickly.' Hospitals want to collaborate with OTPs. We're working on a statewide protocol to make that happen."

SOTA: "The behaviors of the practitioners have been the slowest to change. We have to strike while the iron is hot. COVID was a huge unplanned clinical trial. We're seeing a huge decrease in overdose deaths. But that iron is cooling off. There is the question out there: 'Do we even need those rules anymore?'"

SOTA: "We've been working on the rule changes since 2023. Now we're in the phase of a long-term push. What we need more of is how to get this message to the rank and file. What are we doing to promote long-term change?"

SOTA: "In our state fentanyl overdose rates went from the middle of the pack to the top 10. Overdose deaths have dipped a little. But in rural areas they're continuing to grow. We need an expansion of the infrastructure. And we need culture change on the clinic level. These rules give the patient a choice. They can choose which OTP they like."

AATOD: "The reaction is very different depending on where you are in the state."

Balancing act

Listening to the SOTA responses, Parrino commented on the "balancing act" that the new rules are presenting. "There is financing, and regulation, but it all has to be in service of the patient," he said. Eliminating the requirement that a patient not be admitted without proof of a year of opioid addiction was easy for OTPs. So was raising the induction dose. But engaging patients in counseling and undertaking the clinical decision-making that determines how many take-home doses a patient gets – those are difficult. And they both require change on the part of the OTPs themselves. SOTAs work for the states, and if there is an anti-OTP statehouse or governor, that may come through. Then again, OTPs that want to go farther than the regulations allow – such as by eliminating counseling altogether – face disapproval not only from AATOD but from SOTAs and from the federal government, because counseling can not, under the rule, be eliminated. •

In case you haven't heard...

Our trip to Philadelphia last week to cover AATOD was a joy (and good thing since it was a bit of a busman's holiday). And a reminder that as Rob Morrison of NASADAD has always told us, "You've seen one state, you've seen one state." The wide disparity of state regulations and attitudes, and "cultures" of OTPs within states, shows just how difficult the job of AATOD is to pull them all together. In some states, patients pay for themselves out of their own pockets – and always have. In those states, OTPs see nothing alarming about Medicaid cuts. "It won't affect us." Whereas in other states where Medicaid pays for the vast majority of treatment, the effect will be significant. You have to look at a provider in the eye when they way "it won't affect us" to understand the enormity of the problem.