MEMO IN OPPOSITION:
Assembly bill 8566 /Senate bill 6815
Rules and regulations promoting recovery from opioid abuse and reducing diversion.

This bill imposes regulations on office based clinicians prescribing medication as a part of treatment for opioid use disorder similar to those that must be followed in OASAS licensed programs. It includes formal documentation of education of the patient about medication, even if the patient has been on the medication prior to the regulation becoming effective. More importantly, this formal documentation of consent conveys a sense of risk associated with medications for opioid use disorder which is unsupported by scientific evidence. It also imposes the unnecessary requirement to use an OASAS approved placement instrument and OASAS approved treatment plans. Another unnecessary rule is for counseling by a licensed substance abuse professional when studies have repeatedly shown that counseling provided by the prescriber leads to comparable outcomes for a large number of patients. It includes other unnecessary requirements and threatens penalties if monitoring shows failure to comply. . These regulations and sanctions only apply to clinicians who prescribe opioid agonist medications to treat opioid use disorder, and not to clinicians who prescribe opioids such as OxyContin or other controlled substances for other conditions. Research on buprenorphine diversion has shown that it is greatest in geographic areas where there is limited access to treatment. This bill would reduce access by creating enormous disincentives to practitioners with an interest in providing office based treatment for opioid use disorders. This bill would also make patients who wish to receive treatment in a more flexible, more private setting less inclined to receive treatment. The Federal Government has promulgated standards for office based practices which includes reasonable monitoring and reporting requirements. There is no good reason for New York State to go beyond these standards.

NYSAM opposes these bills for the following reasons:

1. Buprenorphine treatment reduces the risk of overdose. While diversion is a concern there are few deaths associated with buprenorphine, particularly burprenorphine alone. It is vital that access to buprenorphine and methadone be rapidly expanded in order to reduce the deaths and other morbidity of the current opioid crisis. Naltrexone access should also be expanded but at this time there is not yet as strong an evidence base for the impact of that medication on overdose deaths.

2. The standards of care proposed by this legislation are unnecessary and will discourage providers from prescribing medication which is relatively safe and life-saving in the context of the current opioid epidemic. Given problems in access to treatment in many parts of the state, we strongly recommend against burdensome regulations which will make providers more reluctant to treat patients with opioid use disorder. There are no other medications treated as such, including opioids.

3. These regulations are similar to those that govern practice in OASAS clinics and may reduce access to lifesaving medications given that many patients may be willing to see their primary care physician first rather than go to a clinic. There are studies that have shown that additional counseling is not mandatory for a significant proportion of patients with opioid use disorders to have meaningful recovery from addiction. Furthermore, these regulations do not differentiate the patient who has already been on the medicine from someone who has never been on it before

4. If enacted, this legislation could worsen access to life-saving treatment. Many providers would find the regulations impossible to follow for many reasons. In addition, it is not clear that there is a sufficient workforce to provide the additional counseling mandated without regard for patient need. The unintended effect of an insufficient workforce to provide mandated counseling may be a decline in the number of clinicians prescribing medication.

5. It is safe and legal for MD, PAs and NP to prescribe buprenorphine in their practices. The DEA already inspects offices that prescribe buprenorphine to make sure that federal laws are followed, but they do not intrude into the details of treatment decisions, which is a medical decision between clinician and patient. For larger size practices, SAMHSAS already has reporting requirements which are sufficient.

6. The guidelines in this bill are not based on evidence as are the ASAM guidelines for the treatment of people with opioid use disorders,

NYSAMS CONCERN:
This bill will not improve addiction treatment and access in the state for citizens suffering from life-threatening opioid use disorders. New York and other states already struggle to meet the medication access needs of the growing population of patients who need buprenorphine treatment for opioid use disorder. This bill would further worsen this access crisis and lead to worsening of the opioid epidemic. Although we understand the spirit of the bill, it is completely impractical in medical practice and would discourage health care providers to step up to the needs of our communities. Addiction is a medical disease and research has demonstrated that it successfully be treated as such in a medical provider's office.

A SUGGESTION RELATED TO QUALITY OF CARE:
If there are concerns about quality, the sponsors of the bill may write our major insurance companies and encourage them to provide financial incentives for good care as they already do for diabetes, asthma and other diseases which require ongoing care. NYSAM would be pleased to advise on which measures of care might be rewarded. One of the problems in our state is that the insurance companies never offered incentives for proper prescribing of opioids or for treatment of chronic pain or addiction as they do with other diseases. Another important step to improving the quality of care would be to incentivize training for addiction medicine and addressing the workforce shortage. This could be done by supporting Addiction Medicine Fellowships in the states and /or sponsoring Centers of Excellence in Addiction throughout the state that could increase the number of highly trained addiction counselors.