Appendix C: Public Comments on the November 2023 CORE Report Draft That Require Regulatory or Statutory Change

The current report includes only those strategies and tactics considered feasible under the current regulations and laws, whether at the state or federal level, that currently govern Connecticut. This does not preclude potential changes to statute or regulation, supported by strong evidence, which may help achieve the priorities laid out in this report and may require funding. Public comments received on the initial draft of this report included several recommendations that would require a regulatory or statutory change. In this appendix, we have summarized those recommendations and our assessment of the current evidence to support these changes.

Regulatory and Statutory Change to Improve Methadone Access

Background

As noted in our report and highlighted under Priority 1, the evidence-based interventions most likely to reduce overdose deaths in Connecticut are those focused on increasing the use of the most effective medications for opioid use disorder (methadone and buprenorphine) across diverse settings.

The provision of methadone for the treatment of opioid use disorder (OUD) is regulated by federal and state agencies.[1] Currently, under federal law, methadone can only be dispensed for the treatment of OUD from opioid treatment programs (OTPs) regulated at the federal level by the Drug Enforcement Agency (DEA), under standards enforce by Substance Abuse and Mental Health Services Administration (SAMHSA). The Connecticut Department of Mental Health and Addiction Services (DMHAS) serves as the State Opioid Treatment Authority (SOTA) in Connecticut and provides Connecticut-specific oversight. SAMHSA requires in-person physicals before initiation of methadone, daily in-person dosing early on in treatment, and the frequency of counseling services. These regulations limit the provision of methadone in a variety of circumstances and represent barriers for treatment initiation and retention for people with OUD. States and other jurisdictions can, additionally, adopt regulations dictating operations, clinical care, and staffing of their OTPs.[2] The Connecticut SOTA has some flexibility in providing exemptions from SAMHSA regulations.

Individuals engaging in methadone treatment are often required to travel to an OTP daily during the first months of treatment, a burden that is compounded by geographic distribution of OTPs in the state (see Figure 2 on pg. 14) and the fact that many patients rely on mass transit.[3] These regulations also place burdens on OTPs that limit their ability to expand hours. The requirement that patients have an examination by a clinician (recently expanded from requiring a physician to allow nurse practitioners and physician assistants to serve this role[4]) prior to the prescription of methadone for OTP dispensing restricts the provision of same day (and seven day a week) initiation of methadone due to limited clinician supply. As a consequence, many programs limit hours of methadone dosing to morning hours and intake appointments to a few days of the week, further limiting accessibility.

Regulations in the U.S. were temporarily modified during the COVID-19 pandemic to improve access and continuity of treatment under pandemic conditions. In January 2024, SAMHSA made these COVID-19

changes to the rules governing OTPs permanent. For example, prior to the pandemic, individuals engaged in methadone treatment were required to have their methadone administered in-person six days a week for the first 90 days of treatment. After that point, OTPs have discretion to allow methadone to be dispensed to an individual for multiple days of treatment (aka "take-home doses").[5] Take-home doses provide significantly more freedom to patients as they are no longer required to travel to an OTP on a daily basis. During the COVID-19 pandemic, SAMSHA provided guidance allowing for increased discretion to lower thresholds for OTPs to provide take-home doses.[6] Connecticut OTPs did not all apply these modifications uniformly.[7] Data has demonstrated that the rapid increase in access to methadone take-home doses as a result of this regulatory change occurred without a measurable change in methadone poisonings or methadone-associated deaths.[5,7-9]

Finally, the regulatory framework governing methadone access in the United States is different than those in other countries, where primary care/office-based prescribing with pharmacy dispensing of methadone is more common.

Strategy: Update federal and state regulations to enable and fund provision of mobile methadone

The pandemic has catalyzed policy change and regulations governing methadone provision are already evolving to address OUD treatment gaps and improve access to methadone, as evidenced by the adoption of mobile methadone.[10] Mobile methadone units are appropriately outfitted vehicles that travel to different locations to provide medical services filling in geographic access gaps to methadone. In 2021, SAMHSA updated their rules governing OTPs to increase access to mobile methadone clinics and published guidance that states should adopt regulations allowing for the provision of mobile methadone.[11] Currently, Connecticut agencies are actively implementing regulations in line with SAMHSA's guidance that will dictate the provision of mobile methadone in the state. Several OTPs in the state have already expressed interest in supporting mobile methadone programs and our recommendations (Priority 1, Strategy #1, Tactic #5) highlight our endorsement of the use of OTPs to support the ramp up of these programs once the regulatory building blocks are in place.

Strategy: Update federal and state regulations to facilitate pharmacy- and primary-care based methadone prescribing

A model of primary care/office-based methadone in Connecticut that has demonstrated feasibility, safety and good patient outcomes.[12] In 1997 the Connecticut legislature 2 authorized a pilot program to assess the feasibility of methadone maintenance, the Connecticut Methadone Medical Maintenance Pilot Project. We recommend that OSAC review the results of this pilot and consider funding similar strategies.

Further regulatory change is needed and, therefore, we recommend that Connecticut policymakers review legislation being considered in the United States Congress to improve access to methadone (S.644 – Modernizing Opioid Treatment Access Act aka MOTAA[13]) by allowing for pharmacy prescribing and similar innovations like primary care-based dispensing. If federal law is passed allowing for pharmacy prescribing or primary care-based dispensing, we recommend that the DMHAS, DCP, DPH, DSS and other state agencies work proactively to develop the payment, licensure and state regulatory changes needed to implement this model in Connecticut. If this statutory change were to occur, the evidence supports the use of opioid settlement funds to support these efforts.[14]

Strategy: Update regulations to address restrictions and limitations around take-home doses, staffing, and counseling requirements

Notwithstanding changes to federal law that would allow for pharmacy-based dispensing of methadone, we also recommend that Connecticut legislators and policymakers advocate that SAMHSA uses its agency discretion to change rules governing OTPs with an eye towards lowering barriers to methadone initiation, lowering barriers to take-home doses, and loosening rules about staffing or counseling requirements.

Strategy: Organize and fund technical assistance and best practices dissemination for Connecticut OTPs

In addition, we endorse the use of opioid settlement funds to develop and distribute best practices for OTPs in the state and, if needed, support programs to adopt them to promote uniform and low-barrier (e.g., same day) access to methadone throughout the state. We also would have the OSAC consider tying any funding to OTPs to adoption of best practices that promote uniform and low-barrier access to methadone.

Overdose Prevention Centers

Background

We received a number of public comments requesting that Connecticut use Opioid Settlement funds to implement overdose prevention centers (OPC) in the state. Overdose prevention centers, sometimes called supervised consumption sites or supervised injection facilities, are facilities that allow individuals to use pre-obtained drugs in a hygienic environment under direct supervision. If an overdose occurs in an OPC, they can be quickly recognized, medical support can be provided, naloxone administered if needed, and emergency services alerted. In addition, OPCs can provide sterile syringes and other supplies, education, basic medical care, referral to health and mental health services, and rapid referral to addiction treatment. OPCs have been successfully implemented in 16 countries including Canada, Australia, and several European countries. They are also supported by evidence that they likely reduce risk of overdose morbidity and mortality and improve access to care (including addiction treatment), while not increasing crime or public nuisance in the surrounding community.[15]

Under current interpretation of federal and state statutes OPCs cannot currently be implemented. Therefore, we do not recommend funding in our report.

In the United States, officially sanctioned OPCs historically have not been implemented due to threat of federal prosecution under the "crack house" statute and, often, significant local resistance to their adoption. This status quo has been slowly changing with the opening of the first officially sanctioned OPCs in New York City. The experience of New York City has been noted by a large number of overdoses reversed without an overdose death. Initial evaluations have shown no increase in crime or other nuisance complaints in the surrounding community associated with the opening of these two OPCs.[16,17] Following the lead of New York City, both Rhode Island[18,19] and Minnesota[20] have passed legislation to implement the OPC model. Of note, Rhode Island[21] has expressly used opioid settlement funds to support the implementation of an OPC model there.

Strategy: Update state regulations and statutes to enable and implement OPCs in Connecticut

Given evidence supporting OPCs, we support the adoption of statutory and regulatory change in Connecticut to allow for the adoption of OPCs and evaluation of their efficacy in preventing overdose deaths in the context of opioid use epidemiology in Connecticut. If requisite statutory and regulatory changes were to happen, we would support the use of opioid settlement funds to support the implementation of these innovations.

Insurance Reimbursement and Billing Codes from Medicaid and Other Insurers

Background

Health care systems, including both those that are focused substance use treatment service providers and those that provide more general medical care, provide services in response to both the demand for those services but also the ability to be reimbursed adequately for those services. Therefore, there are evidence-based health care services that are not offered or readily available to individuals in the state that might reduce opioid overdose or otherwise improve outcomes for people at risk of an overdose. We received several comments in our stakeholder meetings and via public comments about ways that reimbursement could be changed to address the overdose crisis.

Strategy: Revisit and revise reimbursement policies and billing codes for substance use and SUD related services

Several comments were specific to the use of billing codes and reimbursement for treatment services related to certain subpopulations (e.g., allowing hospitals to bill for inpatient medically supervised withdrawal for children). Other comments were more general regarding the ability to bill for services by non-clinicians (e.g., screening, peer-provided services, addiction counselors), differences in Medicaid reimbursement for services compared to other insurers, and the ability to bill for different services by the same provider on the same day.

Addressing changes in reimbursement or billing practices, often under the purview by individual insurance providers and overseen by a mix of state and federal agencies, regulations, and statutes is beyond the scope of our report, but we acknowledge the role that these changes might have to improve outcomes and achieve the priorities and goals laid out in our report.

Treatment and service provider practices

We received several comments recommending that Connecticut should use its regulatory or statutory power to mandate practices or services provided by health care or other service providers in the state to address the opioid overdose crisis. Examples of these types of recommendations include requiring hospitals to connect individuals at risk of overdose to OUD treatment prior to discharge, mandates on provider education on OUD tied to licensure, and mandates around providing evidence-based OUD treatment or harm reduction services in entities that receive state funding and provide services to people at risk of overdose (e.g., transitional housing/halfway homes, sober homes). We agree with efforts that support the increased provision of MOUD and harm reduction services (see *Priority #1* and *Priority #2*) though do not have particular insight or recommendations into the efficacy of these type of regulatory changes or their use to achieve that goal.

Appendix C References

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