AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Andrew Cuomo
Governor of New York
New York State
Capitol Building
Albany, NY 12224

Re: American Medical Association support for Assembly Bill 2904 and Assembly Bill 7246, An Act to increase access to medication assisted treatment for drug and alcohol dependencies

Dear Governor Cuomo:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing in support of Assembly Bill (A.) 2904 and Assembly Bill (A.) 7246 that would help ensure patients receive—without delay or administrative denial—life saving medication-assisted treatment (MAT) for opioid use disorder. These bills would take New York from a state that has taken important steps to end the opioid epidemic to one that would be viewed as the national leader in removing barriers to evidence-based MAT. More important than titles, however, A.2904 and A.7246 would save countless lives.

National perspective in support of all forms of MAT being available for patients

The nation's opioid epidemic continues to claim more lives each year—particularly from illicit fentanyl, according to the U.S. Centers for Disease Control and Prevention. New York, as in nearly every state, has adopted a wide array of policies designed to reduce opioid supply, increase the use of prescription drug monitoring programs, require electronic prescribing for prescription medications and increase access to naloxone to save lives from overdose. But New York, like most states, continues to see increases in opioid-related mortality, particularly from illicitly manufactured fentanyl and fentanyl analogues.

The Budget Agreement that was signed earlier this year took an important step to require payers to include at least one form of MAT medication in each drug class without prior authorization. Prohibiting prior authorization policies for methadone, buprenorphine or naltrexone will help more patients obtain life-saving treatment. The very manual, time-consuming processes required in these prior authorization policies interrupt care for patients and cause providers (physician practices, pharmacies and hospitals) to divert valuable resources away from direct patient care.

Just as all cancer medication may not work for all types of cancer, not all MAT medications work exactly the same—and that includes medications in the same drug class (e.g., some patients do better on a tablet vs. a sublingual film; and some may do better with a long-term injectable). A.2904 and A.7246 wisely ensure that physicians and patients can work together to ensure that they use the right medication to help

treat a patient's opioid use disorder. Whether methadone maintenance treatment, buprenorphine, naltrexone or other MAT therapies, the evidence is unequivocal that treatment works.[1]

Societal, public health and economic benefits of MAT

MAT helps keep people out of jail, in jobs and with their families, but most importantly—it saves lives. That is why national health insurers such as Anthem, Cigna and Aetna[2] recently announced they will end these policies for MAT, why Pennsylvania's seven largest commercial insurers agreed to end prior authorization for MAT,[3]why North Carolina Blue Cross Blue Shield is ending prior authorization for MAT[4] and why the U.S. Surgeon General's recent "Facing Addiction in America: The Surgeon General's Spotlight on Opioids" report calls MAT the "gold standard" of treatment for opioid use disorder.[5]

We recognize that some payers may raise objections about the potential cost of A.2904 and A.7246. The AMA agrees that physicians must be judicious stewards of health care dollars. We also point out, however, that there are incredible savings that society earns from more widespread adoption of MAT. This includes reduction in injection of illicit drugs and decreased transmission of infectious diseases such as HIV and hepatitis C.[6] It also includes a tangible "return on investment" to borrow an economic term. For example, a study of Vermont's hub-and-spoke treatment system found positive returns with providing methadone and buprenorphine in both "the hubs" and "the spokes."[7] The Commonwealth Fund[8] similarly

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[1] See, for example, resources from the American Society of Addiction Medicine (http://www.asam.org/advocacy/toolkits/opioids) and Prescribers' Clinical Support System for Medication Assisted Treatment (http://pcssmat.org/)

[2] AMA commends Aetna commitment on opioids treatment. See https://www.ama-assn.org/press-center/press-releases/ama-commends-aetna-commitment-opioids-treatment

[3] Wolf Administration Announces Agreement with Insurers to Eliminate Barriers to Medication-Assisted Treatment. See https://www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=344

[4] The Opioid Epidemic: Access Expands For Medication-Assisted Treatment. See https://blog.bcbsnc.com/2018/11/opioid-epidemic-access-expands-medication-assisted-treatment/

[5] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Spotlight on Opioids. Washington, DC: HHS, September 2018. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Spotlight on Opioids. Washington, DC: HHS, September 2018. Available at https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf

[6] Medication-Assisted Treatment Improves Outcomes for Patients With Opioid Use Disorder, Pew Charitable Trusts, FACT SHEET**,** November 22, 2016. Available at https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

[7] Vermont Results First Inventory and Benefit-Cost Analysis Department of Health / Division of Alcohol and Drug Abuse Program's Medication Assisted Treatment for Opioid Use Disorder (Hub and Spoke) Final Report December 2017. The report found: "Providing methadone with health home services in the Hubs had an 88% chance of being cost effective, with a benefit-cost ratio of $1.66…. Buprenorphine with health home services was cost effective 63% of the time, and the benefit-cost ratio was $1.12…. Spokes are cost effective 70% of the time, with a benefit-cost ratio of $1.18. Available at https://blueprintforhealth.vermont.gov/sites/bfh/files/VT%20Results%20First%20Inventory%20and%20Benefit-Cost%20Analysis%20for%20the%20Hub%20and%20Spoke%20Model%202017.pdf

[8] In Focus: Expanding Access to Addiction Treatment Through Primary Care. The Commonwealth Fund. September 27, 2017. Available at https://www.commonwealthfund.org/publications/newsletter-article/2017/sep/focus-expanding-access-addiction-treatment-through-primary

reports that MAT often has "a high return on investment" from savings due to reduced medical costs post-treatment, a reduction of inpatient hospital days and emergency department visits. In addition, the Commonwealth Fund cited a California study of "patients in treatment for addiction involving alcohol or drugs other than nicotine" that "found a benefit-cost ratio of more than seven to one: the average cost of treatment was $1,583 and the benefits were $11,487." Attempting to push a "this cost too much" argument during an epidemic—when the data also suggest cost savings—is an argument that is as misguided as it is false.

Conclusion

The bottom line is that when a patient seeking care for an opioid use disorder is forced to delay or interrupt ongoing treatment due to a health plan utilization management coverage restriction, such as prior authorization, there often is a negative impact on their care and health. With respect to opioid use disorders, that could mean relapse or death from overdose. It is clear that a growing number of states are removing prior authorization for MAT. A.2904 and A.7246 are vital steps to further support patients' long-term recovery.

There is no reason, either medical or policy, for payers to use prior authorization for MAT. Physicians accept that we have a responsibility to prescribe appropriately, use prescription drug monitoring programs, continue to enhance our education, co-prescribe naloxone to our patients at risk of overdose, help reduce stigma and become trained to provide MAT. Through our advocacy efforts and those of the AMA Opioid Task Force, we are committed to doing all that we can to reverse the nation's opioid epidemic.

Thank you for your consideration. We strongly urge you to sign A.2904 and A.7246. We commend your leadership and support on this critical public health issue. If the AMA can be of assistance, please do not hesitate to contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at daniel.blaney-koen@ama-assn.org or (312) 464-4954.

Sincerely,

James L. Madara, MD

cc: Medical Society of the State of New York
Willie Underwood, III, MD, MSc, MPH