Joint Legislative Budget Hearing

Mental Hygiene

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Testimony of The Legal Action Center

Presented by Christine Khaikin, Esq

Senior Health Policy Attorney

Thank you for the opportunity to submit testimony on the FY 2025 Executive Budget proposal. I write on behalf of the Legal Action Center (LAC), a national non-profit organization based in New York City that uses legal and policy strategies to fight discrimination, build health equity, and restore opportunity for people with arrest and conviction records, substance use disorders, and HIV or AIDs.

LAC was one of the founders of and continues to co-chair, coordinate and staff the Coalition for Whole Health, a national coalition bringing together advocates from the mental health and substance use disorder fields. The Coalition played an essential role in advocating for passage of the federal Mental Health Parity and Addiction Equity Act (Parity Act) and ensuring that parity for behavioral health services was a key component of the Affordable Care Act.

In New York State, LAC works closely with the State Office of Addiction Services and Supports (OASAS) as well as several individual addiction providers across the State. In addition, LAC's Director and President, Paul Samuels, was appointed by the Governor in 2013 to be the inaugural chair of the New York State Behavioral Health Services Advisory Council, which advises the State Office of Mental Health and OASAS on issues relating to the provision of behavioral health services and served in that position until 2020. We also provide direct legal services to those impacted by addiction and work to ensure meaningful access to medications for substance use disorder and other substance use disorder treatment, recovery, and harm reduction services.

LAC is the anchor organization for the New York State Parity Coalition. The Coalition was created on the tenth anniversary of the enactment of the Parity Act with the goal of making the law's promise a reality after ten years of little to no enforcement. The Coalition is comprised of 26 organizations from across New York State, including directly impacted individuals, providers of SUD and mental health (MH) services, provider coalitions, as well as other health providers, community- based organizations and legal services providers.

LAC is also one of three specialist organizations supporting New York State's Mental Health and Substance Use Disorder Ombudsman program, known as the Community Health Access to Addiction and Mental Healthcare Project (CHAMP). We provide expert training, technical assistance and client representation related to the Parity Act and other federal and state insurance protections for MH and SUD care.

We continue to live in a dire crisis, with thousands of New Yorkers dying from overdose each year and many thousands more struggling with addiction and discriminatory barriers to housing, healthcare, employment, and criminal consequences. And yet we know that there are solutions out there. There are evidence-based harm reduction services that can not only save lives but provide people with low-barrier access to health care and loving spaces. Medications have been on the market for decades that are proven to treat opioid-use disorder and allow people to begin to stabilize their lives, but so many insurmountable barriers exist to achieve widespread access. While the FY 2025 Executive Budget includes some important funding and reforms, it does not treat the unwavering overdose epidemic as the public health emergency that it is.

Addressing the Overdose Crisis

Part U of the Health and Mental Hygiene (HMH) Article VII of Governor Hochul's proposed budget includes the addition of a long list of fentanyl and xylazine analogs to the State's schedule of controlled substances. The Governor has stated that the goal is merely to align with the federal list under the Controlled Substances Act (CSA) but, this proposal goes well beyond

the federal schedule, including the suggested scheduling of xylazine which is not on the CSA at all.

Scheduling controlled substances is a means of criminalizing those substances. However, substantial evidence demonstrates that criminal penalties have no effect on reducing either the supply of drugs or the demand for them. One study found that states that increased incarceration rates do not lead to a decrease in drug use.[i] Research indicates that an incarcerated drug seller will simply be replaced by someone else to fill the ongoing market demand.[ii] Criminalizing people who possess and/or use drugs does nothing to reduce the harms of drug use and instead amplifies the risk of fatal overdoses, increases stigma and marginalization, creates racial and economic disparities in enforcement, and drives people away from needed treatment, health and harm reduction services.[iii]

Recent reforms to the criminal justice system in New York have aimed to repair and undo the harms caused by mass incarceration and the drug war. There is ample evidence that the harms of the drug war continue to disproportionately impact poor people and communities of color. One recent study of federal criminal drug charges revealed that 75% of all individuals sentenced for fentanyl trafficking were people of color.[iv] Despite recent rhetoric about a "gentler" and health focused approach to substance use, increasing penalties on fentanyl, xylazine, and other synthetic substances is akin to the devastating crack vs. powder cocaine disparities of the past, and will only further exacerbate racial disparities in arrest. In New York's ten most populous counties, where over 70 percent of the overall state population resides, Black people are 13 times more likely to be convicted of felony drug offenses than their white counterparts; there are parts of the state where that ratio exceeds 55:1.

Additionally, the increasing use of archaic drug-induced homicide statutes, do not protect individuals. Those who favor the use and proliferation of drug-induced homicide measures and severe sentencing for drug sellers contend that the threat of harsh sentencing will deter drug use, drug selling, and prevent fatal overdose. This logic is fundamentally false, and decades of ineffectual drug war policies provide evidence to refute this notion. Arresting and detaining a

person for selling or giving a small amount of drugs to another person does nothing to interrupt the availability of fentanyl or any other substances. While these statutes do nothing to decrease use, they do increase drug-war-fueled racial disparities in the criminal justice system. There is abundant research showing that racial bias influences prosecutors' decision making.

The imposition of harsh penalties for possession and/or distribution is also likely to undermine the work that New York is doing to prevent overdose deaths. The threat of police involvement and jail or prison time may make an individual hesitant to call emergency services or run from the scene rather than help the person who is experiencing an overdose. New York's Good Samaritan law can help encourage people to contact emergency services in the event of an overdose, but the law does not protect people in all circumstances.[v]

Additionally, New York State is working to expand the availability of drug checking technology as a harm reduction measure. As more drug checking technology comes online, individuals may avoid utilizing these crucial services for fear that knowing what is in their substance will enhance the potential for criminal penalties. Creating new crimes is wholly at odds and incompatible with the State's harm reduction infrastructure that has been growing throughout the service continuum in recent years in recognition that a person-centered, life-saving approach is successful in preventing overdose, communicable diseases, and connecting people to treatment and recovery supports.

Further criminalizing the sale of substances does nothing to increase public health and safety, nor curb drug use. The real effect of criminalization is to inevitably punish and further stigmatize those individuals who use drugs while also placing those people within a criminal legal system that is not designed to provide public health care. In fact, convictions can serve as an additional barrier to those who are attempting to move on with their life or those who want to focus on treatment and recovery, and only exacerbates issues for people who use drugs who sell or distribute substances to support their own substance use.

Also in Part U is a proposal to expand the ability for the state to utilize data from the prescription drug monitoring program ("PDMP" aka "ISTOP") for public health surveillance and research purposes and to retain that data for ten years instead of five. While we support efforts to understand opioid use from a public health perspective, we are concerned about highly sensitive, personally identifiable data being shared so widely and retained for so long. The data contained in ISTOP can be used to discriminate against individuals in housing, employment, health care settings and the child welfare system. If accessed by law enforcement, it could be used to criminally prosecute someone. The proposal to use personally identifiable, highly sensitive data seems overbroad and unnecessary. Nothing in the proposed definition of "public health surveillance" would require the use of personal identifiers. Public health surveillance and research can and should be done with de-identified data. We also don't see anything in this proposal that would give individuals notice or the ability to consent or opt-out from having their personal data disclosed, used and retained in these new ways. For this reason, we urge the legislature to reject the expansion of the data retention period, and to require that the ISTOP data used for public health surveillance and research be appropriately de-identified before being shared with individuals at the department for any purposes that do not strictly require patient identification.

Funding for overdose and other addiction treatment

The Opioid Stewardship Act established in 2019 requires opioid manufacturers and distributers to pay a portion of their sales into a fund up to $100million annually. Moneys in the Opioid Stewardship Fund are to be kept separate and are to be used to support opioid treatment, recovery, prevention and education. When enacted, the law establishing the Opioid Stewardship Fund was given a sunset date of June 30th, 2024. We urge the legislature to adopt the Executive's proposal in Part X of the Article VII HMH bill to make this fund permanent to ensure OASAS can continue to utilize these funds to support opioid treatment, recovery prevention and education services. Further, we want to ensure that these funds can be used to expand and support existing harm reduction services, such as through suballocations to the Department of Health's Office of Drug User Health (ODUH) to fund Drug User Health Hubs that

provide core services for people who use drugs including low-threshold access to buprenorphine, overdose prevention services and other support services. The ODUH also funds syringe service programs which are critical harm reduction services that provide essential outreach and engagement for people at risk of overdose.

The Executive Budget proposal appropriates funds in the Opioid Settlement Fund according to the prioritization included in the Opioid Settlement Fund Advisory Board's 2023 report and recommendation. We thank Governor Hochul for accepting the recommendations of the board made after several meetings with experts and consumer input. However, we are concerned that the Governor has rejected the Board's recommendation to use funding to support a demonstration project for studying Overdose Prevention Centers (OPCs) and we urge the legislature to take action to the evidence-based, lifesaving work of these centers.

The Advisory Board included this recommendation among others in their report to expand workforce and treatment services because they understand that OPCs are a critical venture actively working to prevent the deaths of Black and brown New Yorkers. The two OPCs operating in New York City have intervened in potentially fatal overdoses more than 1,200 times in two years of operation and have connected people to housing, detox, counseling, and many other services. OPCs have removed syringe litter and other hazardous waste away from streets, parks and buildings. However, these services are currently only available in New York City. The rest of New York City deserves the opportunity to benefit from OPC services, and we all deserve the opportunity to gather more data about their successes.

Strategies to address the overdose epidemic must be robust, anti-racist and responsive to all New Yorkers who are chronically underserved and increasingly at-risk of adverse life and health outcomes. Safe and supportive spaces to prevent overdose death must be available and promoted throughout the entire state as diligently as other crucial public health programs such as cooling centers or vaccinations.

Insurance Reforms for Mental Health and Substance Use Disorder

High costs and administrative insurance barriers continue to be a major impediment to accessing care for SUDs and MH. Although in recent years, several insurance related reforms in our state have alleviated several barriers, including the prohibition on prior authorization of medications for opioid use disorder (MOUD) in both Medicaid and commercial insurance, standards for concurrent review and requirements around medical necessity criteria have all been important steps towards streamlining coverage. Enhanced monitoring for compliance with federal and state parity laws have led to several actions against insurers for violations and last year's mandate to issue network adequacy regulations for MH and SUD coverage will hopefully soon lead to better access to in-network providers. So much more needs to be done to make care and treatment affordable and accessible for New Yorkers using Medicaid and private insurance.

Reimbursement Rates

One key step is to address the problem of unsustainable and inequitable reimbursement rates. We commend Governor Hochul for including Part AA of the proposed HMH Article VII budget that would require NYS regulated commercial insurance plans to reimburse services provided by OMH and OASAS outpatient treatment within their networks at a rate that is at least equivalent to the state mandated Medicaid rate. For a long time, providers have been reporting that the commercial insurance reimbursement rates they receive are lower, and in many cases substantially lower, than what Medicaid provides.

The commercial rates often aren't even enough to cover the actual costs of providing the service, and so providers must rely on other state and federal funding to subsidize the care provided to commercially insured patients. In other cases, these providers simply cannot participate in commercial networks or accept commercially insured patients because it is not sustainable and ends up creating major inequities in care. In fact, the lack of access to care with commercial insurance can be a deterrent to some individuals obtaining full-time employment.

Last year, the final budget included a similar provision to require commercial insurers to reimburse services provided at school-based clinics at least at the Medicaid rate. We urge the legislature to expand this policy to all outpatient services across the state and adopt Part AA in full. Doing so will allow more providers to accept more commercially insured patients and participate in commercial networks and end state and federal subsidies for commercial insurance plans.

Governor Hochul has further proposed to increase reimbursement rates for MH services provided in DOH licensed facilities as well as private practices. LAC supports this proposal but are concerned it does not go far enough. For one thing, the proposal ignores that SUD services in DOH facilities are similarly reimbursed at low rates. In hospitals especially, reimbursement rates fall well below what is necessary to support the services provided. Secondly, in many cases, community-based MH and SUD outpatient clinics are better suited to provide care to individuals seeking MH services as well as SUD services but the budget also does not propose to increase rates in those settings. If the goal is to create a more equitable and accessible MH and SUD care, then we urge the legislature to include language to raise reimbursement rates for MH and SUD must be analyzed across the board and raised accordingly.

Parity Enforcement

In recent years, New York has taken several actions to enforce the federal Mental Health Parity and Addiction Equity Act ("MHPAEA" or "Parity Act") and related New York State laws. Beginning in 2016 with some of the first ever enforcement actions in the country by New York's Attorney General, New York has been a leader in requiring health insurers provide equivalent coverage for MH and SUD services as for health services as required by law. More recently, New York enacted the Parity Reporting Act that requires insurers to publicly post comparative analysis of certain parity metrics and the 2020 Parity Compliance regulations that require all health plans to have internal parity compliance monitoring programs. New York established CHAMP as a first of its kind ombudsman program for MH and SUD insurance coverage that has since been replicated in other states. Most recently, the state has issued fines against some health plans for violations of the Parity Act and other NY Insurance laws.

Despite all these efforts, there is still evidence of discriminatory barriers to accessing in-network MH and SUD care for people with both public and private insurance. We are grateful to Governor Hochul for including the provision of the budget to enhance penalties against commercial insurers for violations of parity as found in Part HH of the proposed Article VII Transportation, Economic Development and Environmental Conservation (TED) legislation and we urge the legislature to adopt it. The possibility of increased fines will hopefully act as a deterrent for insurers whose benefits are still not in compliance with the law. When fines are issued, increased penalties will also increase the amount of money deposited into the Parity Compliance Fund that is used to support parity monitoring and enforcement efforts in the state.

One critical program that is partially funded by this fund is CHAMP. CHAMP is funded at $1.5 million in the budget and last year received an additional $1.5 million from this fund which has allowed the program to greatly expand services by adding five additional CBOs to the network and expanding the ability for the live-answer Helpline to service New Yorkers across the state seeking help with coverage and access for MH and SUD care. We urge the legislature to ensure the additional $1.5 million is again included for a total allocation of $3 million for CHAMP.

Parity requirements and other protections for individuals seeking MH and SUD services through Medicaid Managed Care are also found in the Medicaid Managed Care (MMC) Model Contract. Therefore, the Governor's proposal to impose liquidated damages against Managed Care plans for violations of the Model Contract. We urge adoption of this proposal. The legislature can play a role in holding private and public insurers accountable by ensuring DFS and DOH engage in the robust monitoring and enforcement activities and seek the maximum penalties allowed under the law to deter these companies from violating the rights of New York Consumers.

Thank you for the opportunity to submit this testimony. We are available to answer questions or provide further information. Please feel free to reach out to Christine Khaikin at ckhaikin@lac.org

[i] Przybylski, Roger K. *"Correctional and Sentencing Reform for Drug Offenders."* Colorado Criminal Justice Reform Coalition, Sept. 2009. Available at: http://www.ccjrc.org/wp-content/uploads/2016/02/Correctional_and_Sentencing_Reform_for_Drug_Offenders.pdf

[ii] Roger K. Przybylski, *Correctional and Sentencing Reform for Drug Offenders: Research Findings on Selected Key Issues*, Colorado Criminal Justice Reform Coalition (September 2009). Available at: http://www.ccjrc.org/pdf/Correctional_and_Sentencing_Reform_for_Drug_Offenders.pdf. [v]United States. Drug Enforcement Administration. Strategic Intelligence Section. *Counterfeit Prescription Pills Containing Fentanyls: A Global Threat*. 2016.

[iii] See, e.g., Samuel R. Friedman et al., Relationships of Deterrence and Law Enforcement to Drug-Related Harms Among Drug Injectors in US Metropolitan Areas, 20(1) AIDS 93, 93-99 (2006); Caitlin Elizabeth Hughes and Alex Stevens, What Can We Learn from the Portuguese Decriminalization of Illicit Drugs?, 6 British Journal of Criminology 50 (2010).

[iv] Public Data Presentation for Synthetic Cathinones, Synthetic Cannabinoids and Fentanyl and Fentanyl Analogues Amendments," United States Sentencing Commission, January 2018, https://www.ussc.gov/sites/default/files/pdf/research-and-publications/data-briefings/2018_synthetic-drugs.pdf.

[v] See Assembly Bill 472 (Ammiano 2012) found at http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0451-0500/ab_472_bill_20120917_chaptered.pdf [vi]2023-24 NY Assembly bill number pending