National Association of County Behavioral Health & Developmental Disability Directors
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UNDER THE MICROSCOPE

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DEA Rule Waiver Clears Way for New Mobile Opioid Treatment Programs

Biden Administration, ONDCP Act Press to Expand OUD Treatment for Underserved Americans

ISSUE

Though often overshadowed by the roller-coaster ups and downs of COVID-19 infections and death rates, the rate of U.S. opioid overdose deaths has only accelerated during the pandemic. According to 12-month surveys taken by the Centers for Disease Control (CDC), the rate of overdoses overall rose 29% in the period ending in May 2020 and to 30% during the same period in 2021, claiming more than 93,000 lives during the past year. The combination of pandemic-related social isolation, together with a plentiful supply of illegally manufactured synthetic opioids, notably fentanyl, appear to be the leading factors in the rising overdose fatality rate.

Increasing access to effective treatment is the only way to combat the epidemic of opioid abuse, but how?

A recent regulatory change by the U.S. Drug Enforcement Agency at last makes a new form of treatment outreach possible. On June 30, the DEA announced that it would no longer require the nation's 1,800 registered Opioid Treatment Programs (OTPs) to obtain separate "mobile component" registrations, a restriction that has throttled the availability of mobile treatment outreach programs since 2007. Instead, mobile treatment vehicles can now be included under the same registration as their home brick-and-mortar treatment centers if they operate within the same state.

ANALYSIS

Ending the requirement opens dramatic new possibilities for increasing access to treatment. Instead of requiring opioid-use disorder patients to arrange regular, even daily, transportation to a brick-and-mortar treatment center, local OTPs can now create and dispatch mobile MAT vehicles into underserved areas and deliver Medication Assisted Treatment (MAT), including methadone, buprenorphine and naltrexone, directly to people in need.

It is estimated that just one in five people with OUDs receive any form of treatment. The waiver of this rule opens a potential new lifeline for several major underserved groups of people disproportionately threatened by death from OUDs, including those in isolated rural locations, those separated by distance from urban programs, homebound persons (including pregnant women), homeless people, and jail and prison populations. The expanded outreach and availability of mobile treatment should allow more people to access MAT, connect with service providers for behavioral treatment supports, and maintain treatment continuity within their communities or upon release.

Together with other treatment and payment flexibilities allowed under the federal emergency order related to the pandemic – including greater access to telehealth visits and counseling, more flexibility in buprenorphine prescribing – the recent waiver signals that the Biden Administration and its Office of National Drug Control Policy are serious about improving access to life-saving OUD treatment.

While it opens new possibilities, the rule change isn't perfect, say those who commented on the DEA's Notice of Proposed Rulemaking. Key elements of the NPRM comments are as follows:

1) Mobile MAT service options should enable providers to reach more individuals, provide more treatment, and save more lives at a lower cost. However, some important positive impacts would be difficult to measure, including reduced local healthcare and ED costs, reduced criminal justice involvement and costs, and economic impact due to better worker job attendance and higher productivity.
2) Mobile MAT services are essentially distance limited since they are required to operate only within the same state as the registered OTP and required to "return to base" every day. The DEA saw this requirement as

an essential requirement for sound record-keeping and safeguard against medication theft and diversion, which were the reasons for its long-standing reluctance to allow mobile treatment.

3) The cost of staffing a mobile MAT vehicle (minimum staff include a nurse and medical assistant), plus the back-and-forth travel and vehicle wear, could add up, imposing a de-facto limit on services available to remote areas. Many of those who commented on the DEA rule change said that the time interval for a mobile MAT vehicle to stay in the field should be extended to several days or a week.
4) The DEA agreed that programs limited by the daily "return to base" requirements could apply for exemptions. It noted that OTPs would then have to be responsible for the costs of ensuring the safety of mobile program people, medications, and assets in compliance with federal, state, local or tribal security requirements.
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ACTION

This regulatory change creates a new opportunity for NACBHDD members to work with local stakeholders, institutions, treatment programs, and potential funders to:

1. Highlight the problem of OUDs, rising overdose death rates, and the need for additional treatment alternatives. Just one in five people with an OUD have access to proper treatment.

2. With local opioid treatment program partners, seek out community collaboration opportunities that could help to create and sustain political and financial support for a mobile OUD treatment program:
   - Connect mobile OUD treatment efforts with local crisis intervention programs.
   - Assess needs and opportunities for a mobile effort to serve local jails or prisons, homeless populations, or individuals who are homebound/unable to travel for treatment.
   - Support efforts for expanded rural OUD treatment outreach using mobile resources.

3. Join with state and national advocates to press for increased flexibility and funding to support ongoing treatment at brick-and-mortar OUD treatment centers and mobile treatment operations.

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