AATOD STATE CHAPTER RESPONSES

Mobile Vans

November 22, 2024

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1. Alabama

We do not have any mobile vans. It's not a matter of 'can't,' but rather the hardship posed by all the barriers stemming from classic regulations that we must adhere to. However, I do have some encouraging news: in November, we're having a meeting, and it appears we'll be reverting to the old days when we had more input on regulations.

I hold a seat on the regulatory voting committee, but often, they bypass this process illegally. They assured us that regulatory decisions would be made through a vote, with the majority ruling. I have my doubts, but we'll see. Apparently, this change is slated for November.

If we can dismantle some of these barriers post-meeting, things might become more practical.

2. Alaska

The Alaska clinics have discussed mobile medication units and what that would look like for Alaska during our monthly meetings.

Some noted barriers are the cost, storage, staffing, and the Alaska road system.

- Estimated cost to purchase and ship a DEA approved mobile medication unit to Alaska is $650,000.00.
- Procurement through the state of Alaska was willing to allow $60,000.00 toward vehicle purchases through the state grant system.
- The consensus was that investment by non-profit/for profit would be too costly.
- The SEARHC clinics in Southeast may try to implement a mobile medication unit through their native corporation funding. More information to come.

Clinics were concerned with overnight storage, being in Alaska, we agreed that garage space would be appropriate. The cost of storage would run a minimum of $30,000.00 annually, if we could find a large enough space.

The mobile medication unit would need its own staff, including a nurse, security, and a driver. Clinics struggle to find adequate staffing in the main clinic. Finding additional staffing was considered a barrier.

Operating in a cold climate would be a challenge to include power and RV dumping of gray and black water.

86% of Alaska communities cannot be reached by road, we have a small area that a mobile medication unit could serve. Boat or airplane is the most common ways to access the rural communities.

But, there is good news! We are in the early stages of developing a working relationship with Sonara Health. Sonara would assist us with providing take home medication to increase accessibility to

treatment. More to come, meetings are scheduled for the end of the month. SEARHC in Juneau is using Sonara in clinic at this time. Juneau is completely off the road system, the other Alaska clinics are on the road system between Anchorage and Fairbanks. Alaska OTP regulations adopt the federal regulations, so state regulation is not a barrier.

3. Arizona

MMU:

- CMS Mobile Medication Unit that will serve the rural community of Bullhead, Arizona
- SOR III Funded
- Currently awaiting DEA approval
- Anticipated to open before the end of the year

4. California

Earlier this year, the state solicited proposals for OTPs to develop mobile and fixed-site medication units. They awarded 32 proposals for a total of around $21M. They released a second RFP but received no further interest from providers. Providers have a number of concerns about implementing the units including whether or not counties will contract for ongoing services.

5. Colorado

Colorado experienced significant delays in DEA response to waive the fence requirement for the two units in the state. The wait time was seven months for one and five months for the other, during which time neither unit was operational.

CFR Title 21, Section 1301.72(e)(1) requires any conveyance operated as a mobile narcotic treatment program (NTP) to be parked in a fenced-in area. This presents an undue burden on Opioid Treatment Programs (OTPs) that utilize NTPs to provide essential services and care.

CFR Title 21, Section 1301,72(e)(1) creates logistical and financial barriers for OTPs, particularly in underserved areas where the infrastructure does not support fenced parking spaces. To follow this regulation, OTPs must pay a fee to obtain a building permit from the city and cover the cost of the fence itself which may be upwards of $50,000. This law significantly limits the reach of opioid treatment services which is contrary to the overarching goal of expanding access to medication assisted treatment and services.

The unit must have an alarm and monitoring cameras when not in use. All controlled substances are removed from the units and stored in secure, brick and mortar facilities, rendering the fence requirement unnecessary as a theft deterrent.

Additionally, OTPs can undoubtedly be trusted to safeguard both their vehicles and the patients they serve without a blanket fence requirement.

OTPs should be granted the discretion to implement additional security measures they deem necessary, above the DEA security protocols.

6. Connecticut

In Connecticut, the primary barrier is our Medicaid rate. Our Medicaid authority, the Department of Social Services, has denied our request for an enhanced rate for mobile OTP services. This has caused a significant concern for providers. Because the census for a mobile program is significantly smaller than a brick and mortar program, many organizations are concerned about the long term financial sustainability of the project. The CT Opioid Settlement Committee has addressed the insufficient Medicaid rate for mobile OTP services by allocating 4 million in opioid settlement money to fund two mobile OTP initiatives. The CT Department of Mental health and Addiction Services has issued an RFP to fund these two Mobile OTP initiatives. The grants will pay for the mobile units and subsidize operations for a two-year period.

7. Florida

Medicaid has pretty much hit a dead end and we are still dealing with fee for service that is largely unchanged since 2003 (they did up the bundled 7-day medication rate from $67.48 to $68.08).

Florida OTP mobile units.xlsx

8. Georgia

I am writing to bring to your attention the significant barriers hindering the utilization of mobile vans to treat patients with opioid use disorder in remote areas of Georgia. These barriers stem primarily from the lack of support from key authorities within the state.

As an organization dedicated to advancing evidence-based treatment practices and improving access to care for individuals with opioid dependence, we require increased support for mobile van initiatives in Georgia. By raising awareness of the barriers faced by providers and patients in remote areas, we can work together to overcome these challenges and ensure that all individuals have access to the quality care they deserve.

Mobile Vans in Georgia.pdf

9. Illinois

Illinois we currently have three mobile units. Two in the Chicago area and one in Springfield Illinois. All three are operated by Family Guidance Center, one of them in cooperation with University of Illinois Chicago. All three mobile units are currently in use for outreach and initial induction. None are currently full-service for continuing medication as DEA-Chicago has yet to approve them for such operations.

10. Indiana

INTOD and several other key players like licensing board and DEA participated with Indiana's Division of Mental Health and Addiction (DMHA), which houses the SOTA, to review and provide input on a draft of regulations presented by the SOTA.

Regulations:

At this time of March 2024, the draft is in legal review process. It is expected that these regulations will be released for public comment, editing, and then Governor approval by end of 2024. Official start might not be until 2025, if the above timeline holds. We have been waiting since November 2022 when our workgroup met for the last time.

Current Issues:

We did not see the version that was sent from DMHA to the legal review process. Thus, we do not know what is actually in writing.

During the two workgroup sessions, we inputted then that the current draft was too heavy in the focus of mobile units and medication units as "a privilege" to be used by stable and compliant patients. The logic we explained is that stable and compliant patients typically make progress toward take home status, so being able to access a satellited location, closer to their home is not as strong of a need for them.

We also stressed concern that the current draft of regulations still required potential patients to complete the intake process at the brick and mortar location, with the satellited location meant only for medication dispensing. No counseling, no medical appointments. The draft's focus was misdirected in this regard because providers would not be able to use mobile and medication units to the full potential of bringing all aspects of treatment out to potential patients where Indiana and providers agree have less or more difficult access to treatment (and healthcare in general).

The use of telehealth for methadone induction was pretty much put on hold in our discussions, but we stakeholders noted that should the federal overseers change this allowance, Indiana mobile units and medication units should be allowed to avail themselves of this option in order, again, to make full use of the potential to bring all aspects of treatment out to potential patients.

In Practice:

So currently Indiana has no mobile units or medication units. We do, however, have owner entities operating in the state who have mobile units and medication units in other states. Acadia and Pinnacle Treatment Center are the most experienced in this regard.

I think there is potential for larger OTP's to work on approval for a mobile unit.

In general, medication units may have more financial potential for approval, which Indiana's SOTA envisioned as a satellite stationary location using a dedicated space set aside by another entity - correctional facility or medical provider (hospital, outpatient clinic, etc). Which patients and potential patients have access to this medication unit would not only involve following state regulations but also an agreement between the space provider and the OTP.

*(***revised – October 2024)*

11. Maine

There are currently no mobile vans in Maine. Everest is exploring with the state and no providers have expressed concerns around barriers.

12. Maryland

I have been the CEO of an OTP for the last 6 years. I have been in the Medication Assisted field for over 20 years. The OTP clinic is located in Maryland (southern eastern shore) and within 2 miles of the Virginia state line. I'm licensed in Maryland and credentialed in Virginia to provide Addiction Recovery Treatment Services to Virginia residents due to there isn't any other treatment available and I'm situated within 50 miles of the state border.

I've conducted a Needs Assessment for the Southern Eastern Shore of Maryland/Virginia to identify needs as housing, transportation, treatment, primary care providers, mental health providers, psychiatrists, taxi (Uber/Lyft).

Over the past year, I have been working with the DEA, State of Maryland, and State of Virginia as well as Virginia SOTA with my proposal of a Mobile Water Vessel for the Tangier and Smith Islands. I received an approval from the DEA but the State of Virginia/Board of Pharmacy halted the mobile vessel idea due to the regulations with the Board of Pharmacy and crossing state bodies of water to transport narcotics.

Also, this regulation pertains to Chain of Custody to deliver medication(s) to our patient's that are housed in the Detention Centers and Jails in the Virginia side that are not able to be dosed according to the new law. As an OTP we cannot deliver narcotic medication across state line even when a patient has been admitted into a long term care facility on the Virginia side.

I've attempted to challenge the Board of Pharmacy to make an exception to their regulations due to the opioid epidemic that is happening on the Eastern Shore of Maryland/Virginia. I've heard no response to make any accommodations. It cost an individual daily approximately $160.00 per day to travel by ferry and taxi to come to an OTP clinic closest to their residence. This is the reason I was trying to propose a Water Vessel Mobile Unit.

I've also researched the idea of a Mobile Medication Van for the three counties (Somerset, Worcester, Accomack) surrounding Pocomoke City. But I was informed that due to the Wicomico County Health Department Mobile Van it wouldn't be possible for a full profit OTP to have a mobile van.

13. Massachusetts

Two large for-profit programs that provide OTP services in several states, and 1 large Not for Profit Program. This is what they provide in Massachusetts.

CTC: Two mobile vans operating in Massachusetts. one located in Quincy connected to our Brockton CTC and a the other operates in Wellfleet Mass connected to our Yarmouth CTC.

- One of the big challenges is finding parking lots to use as a service site. Since this is not a bricks and mortar you need an area to park the van each day to deliver services and this is not easy to find especially if you can't connect to hard power to

operate the computers, Etc. you have to run off of generators. Mass has been supportive to mobile vans because we have operated in the state for many years so we are fortunate.

- It is also a small space so finding staff who will commit to working in such a confined space can be a challenge

BayMark/HCRC: In the process of building a mobile unit in Massachusetts. They anticipate that having a mobile units will support MAT in their communities particularly in emergency situations where primary clinics are not able to operate out of their facility.

Spectrum Health Systems: Spectrum has 1 mobile unit, operates out of Worcester and has been very successful. It's been in operation 14 months with 725 unduplicated patients, and an average daily census of 130

- Interested in purchasing another van.
- It's an expensive start up and upkeep. Doing anything else but medicating on the mobile unit can be challenging due to space. Admissions limited to 2x week: utilize space outside of the van at places they park to host a medical coordinator, nurse, and provider.

14. Michigan

We currently have 2 mobile units serving the Detroit area. I've attached the barrier for Michigan in the current licensing rules:

Michigan regulations permit mobile units, which can provide the same services as an OTP and improve access to care. However, the state places restrictions on their operation which exceed federal requirements. Specifically, the mobile unit can only operate from a facility that has been licensed for a minimum of 2 years, and the parent organization can only have a maximum of 3 mobile units.

- The licensee submitting an application for a branch location or mobile unit shall have been licensed for a minimum of 2 years and be in compliance with the public health code, the mental health code, and these rules.
- An application for a mobile unit must be approved if the mobile unit satisfies all of the following requirements:

  (a) The parent organization provides the treatment or rehabilitation service offered in the mobile unit.
  (b) The mobile unit must return each night to the licensed location if the unit offers methadone treatment.
  (c) The total number of mobile units does not exceed 3 for the parent organization.

15. Nevada

Presently, Nevada does not have mobile vans. However, I have spoken with our SOTA, and she is planning to offer an RFP using SRO funding as support. She informed me that the RFP will be released soon, she is behind due to staffing shortages and other obligations.

16. New Jersey

Mobile Medication Units in New Jersey

Current Mobile Medication Units

Medication Assisted Treatment Initiative (MATI)

The Medication Assisted Treatment Initiative (MATI) funds medications for opioid use disorder (MOUD), treatment and ancillary services for New Jersey residents who are indigent with an opioid use disorder, with specific emphasis on providing access for individuals referred by Harm Reduction Centers (HRCs).

Initiative began in 2008 and was created utilizing General State funds created through the State's Bloodborne Disease Harm Reduction Act (P.L. 2006, C.99). All mobile units at the below-listed agencies are licensed as Opioid Treatment Programs (OTPs) and plans to replace vehicles that were purchased in 2008/2009 with Opioid Recovery and Remediation funds.

1. Iron Recovery & Wellness, Trenton, NJ
2. John Brooks Recovery Center, Atlantic City/Pleasantville, NJ
3. Organization for Recovery, Plainfield, NJ
4. Paterson Counseling Center, Paterson, NJ
5. Urban Treatment Associates, Camden, NJ

Mobile Access to Medications for Substance Use Disorder (SUD)
An initiative created and funded through State Opioid Response (SOR) funds to facilitate low induction medication, case management and other ancillary services for those with an OUD in counties with low access to MOUD, as well as areas with individuals who are homeless or at higher risk for homelessness. Currently, the three contracted programs listed below are providing prescriptions for buprenorphine and not dispensing medication, however, they are seeking OTP licensure for these units.

1. Integrity, Newark, NJ
2. John Brooks Recovery Center, Atlantic City/Pleasantville, NJ
3. Spectrum Healthcare, Jersey City, NJ- agency newly contracted February 2024 and purchasing mobile medication unit

Plans to expand Mobile Medication Units
An initiative that will utilize New Jersey's Opioid Recovery and Remediation Funds to support the addition of three (3) new mobile medication units in the State in areas where a mobile medication does not currently exist and where people with a substance use disorder (SUD) may encounter obstacles to receiving services at traditional "brick-and-mortar" OTPs.

Benefits of Mobile Medication Units

1. Part of an innovative strategy that allows the State to deliver treatment services directly to neighborhoods where data shows an unmet need
2. Provides treatment services on demand within the existing continuum of care
3. Works to situate addiction treatment within a public health paradigm
4. Has been utilized to provide methadone to inmates at the Atlantic County Correctional Facility

Considerations in Planning for Mobile Medication Units

1. Type of vehicle- suggest a retrofitted box truck with a separate cab
2. Size of vehicle- a very large-sized vehicle can prohibit easy maneuver on roads and may cause parking challenges in some locations
3. Consider NIMBY issues and try to get in front of it with a public awareness campaign and early discussions with city/town/government officials
4. Funding- third party payers including Medicaid

Opportunities for Mobile Medication Units

1. Low threshold/low demand access (to include going to areas where people experiencing homelessness, harm reduction centers and where there are challenges accessing pharmacies, etc.)
2. Use as part of an emergency management or a State disaster planning strategy
3. Enables access to MOUD in rural areas and/or where siting a clinic may be challenging

4. The Substance Abuse and Mental Health Services Administration (SAMHSA) allows funding through State Opioid Response (SOR) grant and the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) for vehicle purchase

*** *August 2024 Update*

JSAS HealthCare, Inc. was just awarded funding for a MMU (Neptune, NJ). In addition, New Brunswick Counseling (New Brunswick, NJ) and Burlington Comprehensive Counseling (Mt. Holly, NJ) also received awards. That brings the total in NJ to eleven mobile units.

17. New York

On the positive side - New York utilized $6 million in SOR funds and provided grants to fund the start-up costs of MMUs. The funding included proprietary programs. There are 2 MMUs now operating in New York City and another rolling out shortly. The MMUs that were funded outside NYC are making progress toward implementation but are not yet operational.

New York also provided a 40% enhanced Medicaid rate reimbursement for off-site services which can be used for delivering services in an MMU. The main barrier in NYS regarding MMUs is the requirement that all services be offered by the MMU and the staffing requirements.

Below is the section from NY's which outlines the service requirements. The requirement that admission assessments and medication induction led my program, West Midtown Medical Group, to decline the $500,000 grant we were awarded for this project.

- Services – Minimum required and optional additional services
- Provide detailed information on service(s) to be delivered which should include at a minimum, the following services:
    - Medication administration and observation: the face-to-face administration or dispensing of medication, including Schedule II-V controlled substances. Note that at a minimum, both methadone and buprenorphine should be available as part of the dispensing services on an MMU.
    - Admission assessments and medication induction, including pre-admission services and screening
    - Other medical services
    - Toxicology tests

Other barriers include the parking requirements and local traffic regulations which strictly restrict the size of MMUs in urban settings.

18. North Carolina

In NC, it seems that while the State DHHS is looking into making rules for operating a mobile van relevant, there has been NO discussion to my knowledge re: enhanced reimbursement rates to make that service sustainable

Our big concerns are around sustainability with implementation of mobile OTP vans, such as:

Regulations – are they going to be too restrictive to work in various types of settings
Reimbursement – there will need to be enhanced rates for mobile delivery
Start-up costs – the upfront costs and costs for first 6-12 months will need to be subsidized, so grants for this purpose need to be made available
Ongoing M&R costs of the vehicles – there should be some type of M&R funding to pull from to keep these vehicles on the road & safe
Staffing – there will be a myriad of challenges here in terms of getting the right staffing on board and then having backup plans for when staff are not available (eg, sick, vacation, temporary leave, resignation or termination

In NC, some of this is already being discussed – but not all of it… so we will probably have some advocacy work to do with our State officials.

***** October 2024 Update*****
Our status with NC has changed somewhat – now, we have pending rules & policies for mobile OTP vans and for OTP medication units. We are awaiting approval from the State.

19. Ohio

Ohio rules are a barrier to implementation:
The existing state rules are too restrictive that even if we wanted to have mobile units in most instances it is not feasible to do so. For example current law specifies:

5122-40-15(C) Mobile medication units may be located in:

1. Appalachian counties, as defined by https://www.arc.gov/appalachian_region/CountiesinAppalachia.asp.
2. Counties with under sixty thousand residents; or,
3. Areas that are greater than five miles from the nearest opioid treatment program. For example, the rule for citing a Mobile Van is capable of at least three different possible interpretations. With significant limitations to access to OTP/Mobile Van service for Ohioans under all three interpretations.

Proposed updated Ohio rules regarding Medication Units, including Mobile Units have been proposed and are moving through the administrative processes for rule-making in Ohio. Significant progress has been made regarding 'brick and

mortar' medication units, but a significant barrier still is included for mobile units:

Ohio Administrative Code 5122-40-15(B) as proposed:
Mobile medication units may only be located in areas that are greater than five miles from the nearest opioid treatment program.

Using census tract data and geolocated OTPs from SAMHSA's OTP locator were used to calculate these numbers. The proposed rule change would result in Mobile Vans being only capable of serving 46% of Ohioans:

Locating a mobile van within 5 miles of an any existing OTP results in 54% of Ohioans being excluded from service by a Mobile Unit.

Federal Rules at the local level are a perceived barrier:

- Concerns over inconsistent local interpretation of rules by local DEA field agents
- Concerns regarding driving the mobile intra-state, but across DEA field office boundaries
- Concerns regarding broken down or wrecked vehicles while they have medicine supply on board - how to safely return that supply (in ability under current rules to use another mobile van to do so).

Local and practical concerns are a barrier:

- For rural areas, the challenges that prevent potential patients from coming to an OTP are the same that a mobile unit would face.
- Telehealth intakes and the take-home flexibilities may be far more impactful in rural areas - without the investment costs/uncertainties/etc.
- The length of time from planning, acquisition, zoning, and NIMBY make it difficult at best to pursue.
- Geography of Ohio and state's wanting them to be used for rural access, plus
- Vehicle maintenance and down time - almost necessitates the purchase of two vans.
- No time or staff to even devote to pursuing answers to the unknowns surrounding mobile vans
- Requires staff that want to work in a van. The current workforce shortage in Ohio means that unless the nurse/counselor/etc… wants to work in a van driving around the state every day, it will be impossible to staff the van.

Funding as a barrier:

- Cost of vehicle(s) (initial capital outlay with uncertainty of ability to sustain)
- Cost of ongoing operation, maintenance, repair and ultimately replacement of vehicle. Buildings don't often have accidents, even natural disasters impacting facilities are thankfully rare. Accidents on the road are common and must be built into a model of sustainability.

- Lack of any base funding mechanism to "cover the capacity of having mobile services" - without an enhanced rate or base grant funding + Fee for Service, the mobile van would never be viable or sustainable.
- Lost opportunity during transit - credentialled staff can work 8 hours at brick and mortar site, but would lose potential of reimbursable time during transit there, back. Resulting in it being unlikely that Fee for Service or any non-dedicated rate would cover the cost of the staff required to be on board the van. This is complicated by workforce shortages - providers have need of staff at brick and mortar locations too.

20. Oklahoma

The state regulations are very flexible with the mobile vans and create an easy path to approval. We have a number of mobile vans doing buprenorphine at this time and do not report any difficulty with DEA. However, since no one has applied for a van for the use of methadone we don't know yet how the process will go here in Oklahoma. We have our next provider meeting in the first week of November, and I look forward to sitting down in person with our brand new interim SOTA to determine if there is any interest in our state.

21. Oregon

For Oregon, we have at least two mobile units and one pending as well as one medication unit. I believe the barriers for more mobile units is the reimbursement rates vs the cost of operating the vans. Especially when thinking about more rural parts of Oregon and the travel time to get to one place and then back to the home clinic. The vans are also expensive and the upkeep has been some of the concern that I have heard.

22. Pennsylvania

- Public hearings to discuss to validity of the program;
- Council meetings to establish intent, land usage, traffic monitoring, etc.
- Legal support in regards to the Council meetings and subsequent voting;
- Seeking approval from state/fed officials, including licensure, DEA, BOP, etc.
- Zoning requirements/restrictions for the land to be used;
- Securing stable, consistent staffing for the unit;
- Requirements for the storage of the unit, as well as the transportation to and from the location on a daily basis.

23. Rhode Island

RI currently has 2 full size mobile medical units dispensing all FDA approved medications for opioid use disorder. These re-purposed recreational vehicles are 32 and 35 feet long inclusive of a DEA approved dispensary, an exam room, small space for consultation or counseling and a restroom. The first has been in operation since August of 2022. We average 100 patients per day served for methadone dispensing and we serve communities for general medicine: wound care, blood pressure, etc.

Our units are staffed with a driver, of course, (we mandate a CDL license however the State doesn't), security staff, a peer recovery support specialist, a case manager and a counselor. These staff drive to the site where the medical mobile unit is co-located with one of our community partners, and can therefore assist the persons being served with transportation. We have nursing staff every day and a physician twice a week along with telehealth that allow for treatment upon demand. All services are available 6 days a week. These services have been received extremely positively by the community of individuals who need our care. CODAC is currently measuring the efficacy of mobile treatment with a grant from NIH (JCOIN). We're excited to have this solid data and analysis from Brown University by May 2025.

We have encountered barriers to providing this care. These barriers are primarily political in nature and of course supported by stigma and by lack of knowledge. We have gratefully received support from

our state and from our respective communities to enable the provision of these services. It is critically important for any of us as we move forward providing this venue of care, to assure that any negative consequence of a mobile medical unit being in a community setting is either anticipated and mitigated or reconciled immediately. It is also important to address any concerns with community entities with immediacy. We provide a critical service. When we do it well we are absolutely doing the right thing. Communication is primary for strong community relationships. Each community has its own culture, has its own personality, has its own leaders. When we respect the importance and autonomy of each of these variables we greatly enhance a successful outcome.

24. South Carolina

The barriers in SC align with many of the concerns raised by my board colleagues at the meeting, the primary of which is financial. Our state authority did put out feelers last year about the interest in a mobile unit if they were to provide some funding for the initial development; however, the amounts they were potentially offering were around 300K. As you know from the cost estimates shared at our meeting, this might not even be sufficient for the start-up cost of a single unit.

At the time our state was putting out feelers, I did reach out to Mike Santillo who, as you know, has experience operating mobile units in New Jersey, to try to get a sense of the operating costs of a mobile unit and whether it would be financially viable. The feedback I received made it clear that it would not be. In NJ the

mobile units rely on additional/ongoing funding from their state to support operations. Mike indicated that their regular OTP reimbursement/payment structures would not cover the operational costs of a mobile unit.

It is important to also keep in mind that, as a non-expansion state, Medicaid represents a very small portion of our patient population in SC. The population served under our SOR grant is even smaller. Illustratively here is the breakdown of payers from my own organization's SC programs:

- SOR Grant: 7%
- Commercial Payers: 13%
- Medicare: 13%
- Medicaid: 19%
- Self-pay/out of pocket: 48%

Even if SC were to adopt an expanded Medicaid rate for services provided on a mobile unit, significant grant support would be needed. Right now, all SABG dollars go to the SC county drug and alcohol commissions, only one of which operates an OTP. The only grant support received by the private OTP sector are SOR dollars, and this pot is very limited.

I will say that it is looking likely that we are about to undergo a significant state reorganization which may impact how grant dollars are administered. It is looking like a bill which proposes to combine several state agencies (including our drug and alcohol agency, mental health, our licensing body, SC DHHS, and others) is going to pass. So, we'll see what the future holds.

25. Washington

This is the information that I have received from our programs that have MMUs.

Cost of Mobile Dispensing Unit
Financial sustainability of operating the unit at typical daily rates
Strange DEA rules on the unit, such as requiring it be parked overnight on site at the OTP to operate under their license.

1. Licensing – multiple layers of government involved and a lack of clear process and insufficient support in navigating. We also developed a white paper on this topic after licensing the MMU we already had in operation when the new DEA guidelines were released. DOH has updated their website to more clearly reflect the process, but the bureaucratic barriers remain in terms of how quickly things can move along.

2. Reimbursement – the OTP dose day reimbursement model does not sufficiently support this work. This is due to a loss of efficiencies of scale (higher staff to patient ratio) and lack of reimbursement for travel time, and time associated with set up and break down. We took part in the legislative advocacy that will be changing the payment model in WA state.

3. Community stigma – this isn't new for OTPs, but does apply to MMUs also. NIMBYism is alive and well, despite folks wanting to address the opioid and fentanyl crisis. We have had success doing proactive community outreach and education, but it remains a barrier for those wanting to bring treatment to the communities that need it.

26. Washington, DC

We had a discussion regarding mobile vans with the OTP's and a few representatives from the city. The City and the SOTA are definitely interested is moving mobile vans forward. The city reports they have the money to pay for the van.

The OTP's had several concerns about moving forward. Mainly costs, storage, staffing, city regulations and MOTAA all came up.

Everyone thinks they are good idea and that specific meetings need to be scheduled with the city and OTP's.

At this point, I would say it's the OTP's slowing down mobile vans getting started in the District of Columbia.

27. Wisconsin

Barriers for mobile OTP's:

- Getting insurance on the unit
- Installing the proper power supply for the unit to be plugged into the brick and mortar facility
- Establishing relationships in the community to be able to park unit only to then have city come back and state it's a zoning violation.

- Medicaid patients losing income by coming to mobile unit instead of going to brick and mortar facility. Example:' Some states pay individuals to transport themselves to medical appointments instead of using medical transportation through the state. These individuals all ride in one vehicle to the furthest OTP from their home. Even though only one vehicle is used everyone submits to Medicaid for transportation reimbursement for daily trips. This adds up over the month to several hundred dollars. Patients are not going to give up additional income even though they could be served closer to home. (This issue is not only for mobile units but also for brick and mortar locations across the country.)
- State staffing requirements for the mobile units.
- Ongoing maintenance of the vehicle (oil changes for generator, emptying of black water, cold weather upgrades).