NYS ASSOCIATION FOR RURAL HEALTH

ISSUE BRIEF

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Administrative Barriers Cripple Implementation of Mobile Opioid Treatment in Rural New York

Introduction

Of 144 opioid treatment programs (OTPs) statewide, just 23 reside in rural New York counties, leaving 25 of New York's 44 rural counties without a local OTP (see **Figure 1**).[1] In some cases, individuals without a local OTP may have to travel several hours daily to receive medication, presenting major barriers to accessing and sustaining treatment services.

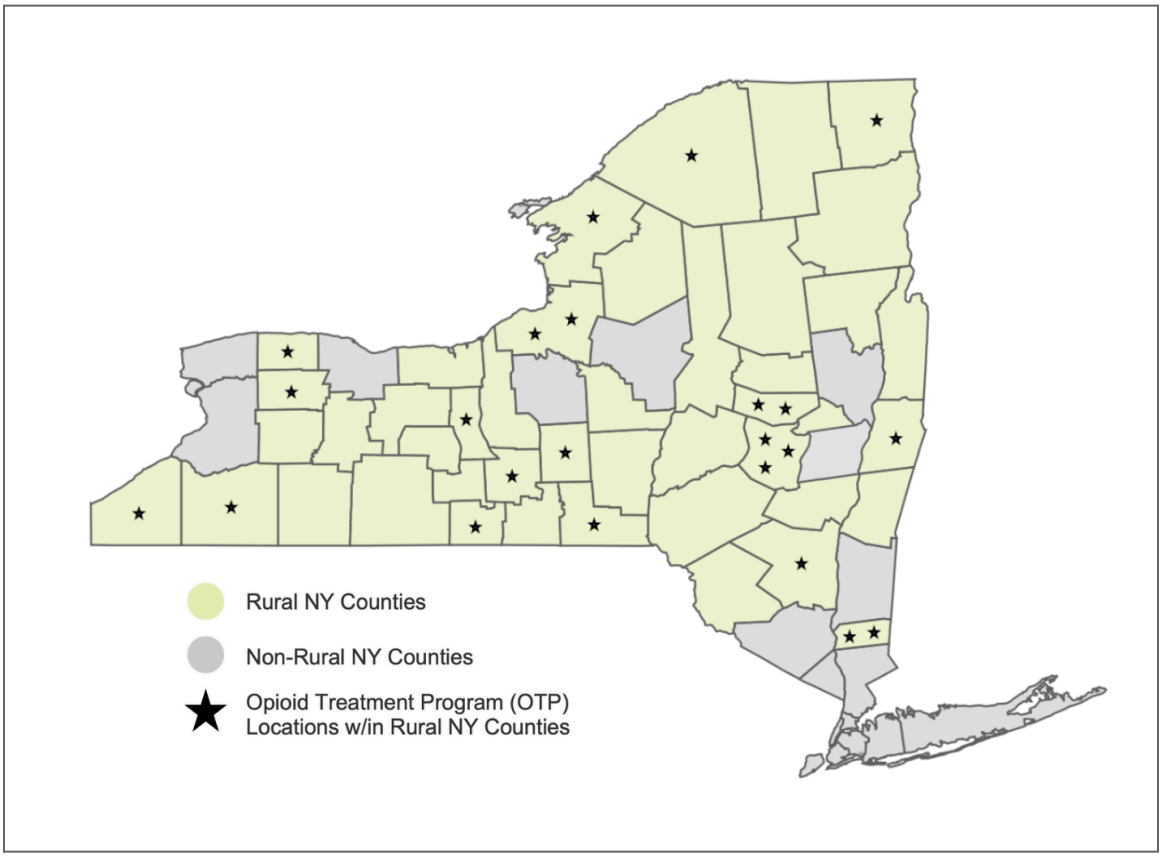

Figure 1: Map of New York State counties illustrating disparities in access to opioid treatment programs (OTPs) in rural NY counties versus non-rural NY counties. Map was created using https://www.smartdraw.com/. Data was sourced from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Opioid Treatment Program locator tool (https://dpt2.samhsa.gov/treatment/).

To reduce the burden of travel for patients receiving methadone therapy, mobile medication units (MMUs), often repurposed vans or RVs, can be used as additional locations for OTPs and can provide similar services, such as dispensing medication, like methadone. This issue brief explores the feasibility and challenges in utilizing MMUs to bridge the gap in OTP access for rural communities across New York State.

Background

In New York State, overdose deaths involving any opioid increased 400% from 1,074 deaths in 2010 to 5,361 in 2022.[2] While provisional data indicates rates have slightly declined from 2023-2024, the severity and disproportionate impact of the opioid crisis, particularly in rural areas, emphasizes the importance of expanding access to prevention, treatment, recovery, and harm reduction resources, specifically medication(s) for opioid use disorder (MOUD).

The United States Food and Drug Administration (FDA) has approved three medications to treat opioid use disorder (OUD): methadone, buprenorphine, and naltrexone. These medications are intended to help individuals stop or reduce opioid use, lessen symptoms of withdrawal, and weaken drug cravings without creating the strong pleasurable effects opioids may have on the brain.[3] Of these medications, methadone is the most frequently prescribed but most highly regulated, and can only be administered by certified OTPs. Individuals treated with MOUD, including methadone, are less likely to experience or die from an overdose, less likely to engage in behaviors that put them at risk for HIV or hepatitis C infection, and more likely to remain in treatment consistently without disruption. Although the efficacy of methadone and other medications for opioid use disorder is well known, less than 20% of people with OUD receive them.[4]

One of the largest barriers to MOUD access for those living rurally is the distance required to travel to receive treatment at a certified OTP. Compared to their urban counterparts, accessing OTPs took rural residents two to five times longer, a substantial obstacle to care, particularly for those with limited access to public transportation or without a personal vehicle.[5] Mobile medication units (MMUs) address this issue by traveling between a fixed site (typically an OTP) and another location to provide services to patients living in an OTP desert.

In 1988, the United States Drug Enforcement Administration (DEA) approved the first MMU to effectively increase methadone treatment across rural and urban areas, without the need for a brick-and-mortar OTP. These approvals continued until 2007, when a

moratorium was issued due to concerns about potential methadone diversion.[6] This moratorium was lifted in 2021 in light of the increasing severity of the opioid epidemic in the U.S. As of April 2025, 68 MMUs operate across 18 states, demonstrating growth from 8 operational MMUs across 6 states as of August 2022.[7] Of currently operational MMUs across the United States, 4 are located in New York, of which two are in New York City. Over the last several years, New York State's Executive Budget, namely FY21, FY22, and FY23, have included information about expanding access to evidence-based treatment services through mobile treatment vehicles, but did not specify that funding was specifically appropriated to support MMUs.[8, 9, 10] However, the NYS FY26 Executive Budget included the explicit allocation of $2.5M to expand the number of MMUs in the state.[11]

Despite the rapid expansion of the use of MMUs across the nation and inclusion of mobile treatment goals in State Budget Briefs, administrative requirements, underfunding, and sustainability challenges plague organizations who desire to operate and maintain an MMU, especially in rural areas.

National, State, and Local Policies Related to Mobile Medication Units

The DEA serves as the primary regulatory authority overseeing the registration and operational requirements for Mobile Medication Units. This oversight includes issuing permits and registrations, defining approved service areas, enforcing security protocols, maintaining record keeping standards, and more. In addition to DEA regulations, MMUs may also be subject to other requirements based on their geographic location or the stipulations tied to their funding sources. It's important to note that while the DEA governs operations, it does not regulate the funding of MMUs. Funding typically comes from a range of sources, including:

- State grants (such as California's Mobile Narcotic Treatment Programs and Medication Units Grant);[12]
- Federal grants (such as New York State's Office of Addiction Supports and Services' (OASAS) Mobile Medication Unit II Grant, funded by the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration, (SAMHSA));[13]
- Opioid settlement funds (referring to settlement payments made to states, counties, and cities across the U.S from opioid manufacturers, distributors, and pharmacies as a result of their role in contributing to the opioid epidemic).[14]

Although MMUs must comply with a broad set of regulations, a select few rules more directly impact their day-to-day operations. These include, but are not limited to:

- *Federal Regulations*
    - Require that the MMU return to its registered home location on a daily basis;[15]
    - Prohibit the pre-approval of contingency plans for dosing patients in the event of inclement weather or vehicular issues (the DEA does, however, require a contingency plan for securing and safeguarding any controlled substances within the MMU in the event the vehicle must stop service due to weather, mechanical failure, or other causes);[16]
- *New York State Regulations*
    - Requires that OTPs and MMUs submit a certificate of need (CON) to demonstrate a community need prior to establishing or expanding a healthcare facility or service;[17]
    - Require that all OTPs be OASAS-certified;[18]
- *Local Regulations*
    - Require MMUs to comply with local zoning regulations, which vary by municipality.[19]

Barriers to Mobile Medication Unit Implementation

Return to Home Requirement

According to the DEA, upon the completion of servicing a particular area, a mobile medication unit must immediately return to its associated brick-and-mortar OTP, remove all controlled substances, and secure them within the OTP.[20] For areas in New York State that may not have an OTP for 50+ miles, such as regions of the Southern Tier, Finger Lakes, and North Country, this significantly limits the geographic range and operating hours of the MMU. Clinicians that staff the vehicle must consider travel time as part of their work day, meaning the mobile unit can realistically only travel so far without severely limiting the window of care they are able to provide to patients.

Up-Front Costs

Most MMUs cover the cost of start-up through funds received via federal grant programs, other state-specific funding that OTPs receive by responding to requests for proposals, or philanthropic funding. In the majority of cases, this funding is awarded one time only to cover the cost of MMU establishment, and is not part of a multi-year funding mechanism. Vehicle costs can range from $300,000-$500,000 depending on the configuration and specializations of the unit, as well as if the unit was purchased from a company that guarantees the vehicle will comply with DEA regulations.[21] In certain instances, these costs are representative of what is required to simply purchase and outfit the vehicle, not

including ongoing expenses like maintenance, or funds to bridge the gap between start-up and obtaining enough clients to be financially sustainable.

Timeline from Grant Award to Project Initiation

In August of 2022, one-time, $550,000 awards were made to OTPs through the New York State OASAS Mobile Medication Unit Request for Applications.[22] An OTP in Syracuse, NY received one award to establish an MMU serving both the Mohawk and Central regions of the state, but did not officially launch until March 2025. A nearly two-and-a-half year turnaround time from grant award to the vehicle's launch can be attributed to a variety of administrative and bureaucratic hurdles, significantly delaying the OTP/MMUs ability to begin serving its designated communities.

Sustainability of MMUs

The sustainability of MMUs hinges on various financial, vehicular, geographic, and staffing conditions:

- *Financial Considerations*: While initial funding relies on grants, the long-term model aims for financial self-sufficiency through insurance reimbursements once a target patient volume is reached. While urban centers such as New York City, home to two of four NYS MMUs, benefit from a readily accessible patient base and near-guaranteed insurance reimbursement, the situation differs drastically in rural New York. For rural New York counties that are often more sparsely populated and farther from larger cities, reaching the necessary patient volume to ensure financial sustainability through insurance is uncertain. To address this, NYS has taken steps to improve financial support. Effective January 1, 2023, freestanding programs, including MMUs operating under a certified OTP, receive a 40% insurance reimbursement differential for services provided to the community. Additionally, as of July 1, 2024, MMUs became eligible for bundle billing under the Ambulatory Patient Group (APG) methodology, allowing MMUs that provide at least one of a specified set of services to qualify. Despite updated regulations on billing and reimbursement, MMUs still report financial obstacles as a result of existing billing structures. NYS could consider the implementation of a small, additional, reimbursement differential to MMUs who meet a minimum rural service requirement. This would not only ease the financial burden on rural programs, but further incentivize OTPs to apply for and operate MMUs in rural areas.
- *Vehicular and Geographical Considerations*: Nearly 19,000 miles of road in New York are unpaved, primarily rural local roads.[23] On top of operational and maintenance expenses resulting from routine mechanical and electrical wear-and-tear, mobile

units navigating rural areas may experience further issues as a result of deficiencies and variations in road infrastructure. Additionally, several areas of New York are recipients of severe weather during the winter months, particularly regions bordering Lakes Erie and Ontario, such as Western NY, the Finger Lakes, Central NY, and the North Country. Mobile units may not be equipped to travel during severe weather, and for those that do, there is risk of vehicle damage or becoming stranded.

- *Contingency Planning for Service Interruptions:* For MMUs with an elevated risk of disrupted service due to the aforementioned issues, the DEA lacks explicit language outlining procedures for pre-approval of secondary or back-up vehicles, as a vehicular contingency plan is not a mandatory requirement of registering an MMU. OASAS could further support MMUs, especially those in rural areas, by establishing a system for pre-approving secondary vehicles, allowing OTPs with a higher risk of service disruptions to have a back-up MMU on standby. Additionally, OASAS could explore creating a statewide patient transport program to assist residents in rural counties with non-emergent travel to their treatment appointments.
- *Staffing Considerations*: MMUs typically operate with a team of three to five individuals present on the vehicle at any given time. This includes required staff for care delivery (nurses, counselors, peer support workers, medical providers, etc.), security personnel, drivers, and administrative support for billing. Limited space in the vehicle constrains the number of staff and patients who can be onboard, demanding that a full spectrum of necessary services be provided without exceeding spatial limitations. Recruiting and retaining staff is further complicated by travel requirements (time and location), the need to work in adverse weather, and New York State's existing behavioral health workforce shortage. The rigidity of this staffing structure means that any absence, whether due to illness or turnover, can significantly impact patient care, as on-call replacements are generally unavailable.

Local Zoning Regulations

In identifying a location for MMUs to provide services, many organizations face challenges from the community stemming from the negative stigma associated with substance use disorders (SUDs), their treatment, and the recovery process. This often severely limits the places within a community where MMUs can park and effectively operate during their service window. As a result, MMUs may be forced to operate in locations far from accessible public transportation routes or difficult to locate for those unfamiliar with the area. This added burden disproportionately impacts unhoused individuals, those in rural

areas with limited access to reliable transportation, or those lacking the financial capital to travel.

Summary

Access to opioid treatment programs in New York State is inequitably distributed, particularly in rural areas, creating significant barriers to receiving and sustaining treatment. Mobile medication units offer a viable strategy to enhance treatment accessibility in these areas, yielding potential cost savings through the prevention of emergency room visits and hospitalizations associated with untreated opioid use disorder. However, the effective establishment and long-term viability of MMUs are constrained by stringent federal regulations, substantial initial capital investments, drawn-out establishment timelines, and concerns around financial sustainability, geographical and meteorological considerations, and staffing limitations. Addressing the opioid crisis in rural New York necessitates an approach that is multifaceted in nature; this may include policy modifications at the federal level, improved and sustained financial investment, streamlined administrative procedures, and the development of context-specific strategies to ensure the successful implementation and enduring operation of MMUs.

References

1. Substance Abuse and Mental Health Services Administration (SAMHSA). “Opioid Treatment Program Directory.” https://dpt2.samhsa.gov/treatment/.
2. New York State Department of Health. “New York State Opioid Annual Report 2024,” 2024.
3. National Institute on Drug Abuse. “Medications for Opioid Use Disorder,” March 20, 2025. https://nida.nih.gov/research-topics/medications-opioid-use-disorder.
4. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. “National Survey on Drug Use and Health 2022-2023,” n.d. https://www.samhsa.gov/data/sites/default/files/reports/rpt56185/2023-nsduh-sae-tables-percents/2023-nsduh-sae-tables-percent.pdf.
5. Amiri, Solmaz, Katherine Hirchak, Michael G. McDonell, Justin T. Denney, Dedra Buchwald, and Ofer Amram. “Access to Medication-Assisted Treatment in the United States: Comparison of Travel Time to Opioid Treatment Programs and Office-Based Buprenorphine Treatment.” *Drug and Alcohol Dependence* 224 (July 1, 2021): 108727. https://doi.org/10.1016/j.drugalcdep.2021.108727.
6. Chan, Brian, Kim A. Hoffman, Christina Bougatsos, Sara Grusing, Roger Chou, and Dennis McCarty. “Mobile Methadone Medication Units: A Brief History, Scoping Review and Research Opportunity.” *Journal of Substance Abuse Treatment* 129 (October 1, 2021): 108483. https://doi.org/10.1016/j.jsat.2021.108483.

7. DEA. “Registrant Population by State and Business Activity.” 2024. https://apps.deadiversion.usdoj.gov/RAPR/raprRegistrantPopulationByStateAndBusinessActivity.xhtml.
8. New York State Division of the Budget. *New York State FY 2021 Executive Budget*, 2021. https://www.budget.ny.gov/pubs/archive/fy21/exec/book/briefingbook.pdf.
9. New York State Division of the Budget. *New York State FY 2022 Executive Budget*, 2022. https://www.budget.ny.gov/pubs/archive/fy22/exec/book/briefingbook.pdf.
10. New York State Division of the Budget. *New York State FY 2023 Executive Budget*, 2023. https://www.budget.ny.gov/pubs/archive/fy23/exec/book/briefingbook.pdf.
11. New York State Division of the Budget. *New York State FY 2026 Executive Budget*, 2026. https://www.budget.ny.gov/pubs/archive/fy26/exec/book/briefingbook.pdf.
12. California Department of Healthcare Services. “Narcotic Treatment Programs Medication Units - Round Two Request for Applications,” March 2025. https://mataccesspoints.org/wp-content/uploads/2025/03/MU-RFA-Final_2.28.25_ADA.pdf.
13. Office of Addiction Services and Supports. “Mobile Medication Unit II (# SUPP1012).” Accessed April 19, 2025. https://oasas.ny.gov/rfa/mobile-medication-unit.
14. Office of Addiction Services and Supports. “Opioid Settlement Funding Initiatives.” Accessed June 2, 2025. https://oasas.ny.gov/opioid-settlement-funding-initiatives.
15. Federal Register. “Registration Requirements for Narcotic Treatment Programs With Mobile Components,” 2021.
16. Nguyen, Rosette, Colleen Staatz, and Michaela Vine. “Implementation of Mobile Medication Units: Findings from a Qualitative Study,” January 2025. https://aspe.hhs.gov/sites/default/files/documents/80100760ee84168f3fbc1dd56184c121/implementation-mobile-medication-units.pdf.
17. Office of Addiction Services and Supports. “Program Certification.” Accessed April 21, 2025. https://oasas.ny.gov/providers/program-certification.
18. New York State. Mental Hygiene Law Sections 19.07(c), 19.07(e), 19.09(b), 19.16, 19.21(b), 19.21(d), 19.40, 32.01, 32.05(b), 32.07(a) 32.09(b), 22.07(c); Penal Law Section 220.78; Public Health Law Section 3309, 2781; 42 CFR Part 8], 14 CRR-NY XXI 822 § (2022). https://oasas.ny.gov/system/files/documents/2022/09/822.pdf.
19. “Land Use Planning and Regulation.” Accessed April 21, 2025. https://video.dos.ny.gov/lg/handbook/html/land_use_planning_and_regulation.html.
20. Federal Register. “Registration Requirements for Narcotic Treatment Programs With Mobile Components,” June 28, 2021. https://www.federalregister.gov/documents/2021/06/28/2021-13519/registration-requirements-for-narcotic-treatment-programs-with-mobile-components.
21. Nguyen. “Implementation of Mobile Medication Units: Findings from a Qualitative Study,” 2025.
22. Office of Addiction Services and Supports. “Mobile Medication Unit II (# SUPP1012).”
23. Office of the New York State Comptroller. “Locally Owned Roads by the Numbers,” January 2022.

https://www.osc.ny.gov/files/local-government/publications/pdf/locally-owned-roads-by-the-numbers.pdf

Appendix A - Abbreviations and Acronyms

APG	Ambulatory Patient Group
CON	Certificate of Need
DEA	Drug Enforcement Administration
FDA	Food and Drug Administration
FY	Fiscal Year
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
MMU	Mobile Medication Unit
MOUD	Medication for Opioid Use Disorder
NY	New York
NYS	New York State
OASAS	Office of Addiction Services and Supports
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
RV	Recreational Vehicle
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder