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Introduction

- The central issue in the adoption of buprenorphine, identified by a number of studies, is the *attitude of practitioners toward the use of medications in opioid treatment.*
- Without attention to attitudes toward medication, the necessary effort to finance it, identify reimbursement, make patients eligible for insurance, and arrange for other important clinical services will not happen.

Introduction

- Treatment organizations are critical to influencing physician practice patterns; they need more than education to change cultural attitudes – perhaps even contingent federal funding.

- The interplay of medical organizations with their independent professionals with addiction treatment organizations needs further attention.

Context

- Between 2003 and 2007 prescriptions rose from 48,000 to about 2 million. Among all physicians, primary care practitioners wrote the most prescriptions – on average about 38% (Mark et al., 2008)
- Among specialty physicians, within 3 years of approval of buprenorphine, 90% of addiction specialists had been approved to prescribe it and over 65% treated patients with buprenorphine.
- Only 10% of non-addiction specialty psychiatrists presecribed it. (Thomas et al.,2008)

Context

- In the public sector, among addiction specialists, organizational influence -- support and training – is very significant for adoption; non-addiction specialists, those not affiliated with addiction treatment programs or in small clinical practices rarely prescribe (Thomas et al., 2008)
- In the private sector, studies suggest that about one-third of private insurance benefit packages exclude buprenorphine from formularies and over half place in on the highest cost-sharing tier (Horgan et al., 2008).

Public Sector Issues

- Among psychiatrists and/or primary care physicians not affiliated with addiction treatment programs what are the financial or other incentives to get trained and prescribe buprenorphine?
- How do physicians without organizational affiliations get access to the clinical treatment services needed to support buprenophine treatment? What added financial resources do they need?

Private Sector Issues

- Given the medical care cost savings use of buprenophine has shown in studies, what is the real concern private insurers have about reimbursing this medication under their plans?

- How can collaboration with primary care group practices enhance use of buprenorphine as a component of treatment?

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Coverage

- Coverage is necessary and may look adequate but is rarely sufficient to assure access.
- Coverage is often hedged with so many hurdles and restrictions that access appears possible when it is actually unlikely except to highly motivated persons or those who can pay out of pocket for care.
- Therapy and lab tests are components of treatment benefits, while medications fall under the pharmacy benefits – these are different benefits with different design issues and hurdles and may have different administrators

Pricing

- Pricing of medications themselves is an issue as well as the long formulary approval processes.
- Pricing issues can be resolved with negotiation if a plan or public agency is convinced that it is beneficial enough to be worth making the negotiation effort
- Being able to offer and/or activate links to the needed counseling and recovery support services directly or via funded case management is another critical issue

AvisaGroup Survey Findings (2008)

- Buprenorphine is the opiate dependence medication most often reportedly “covered” by Medicaid

Coverage	Number States
Offer Medicaid coverage of methadone in NTPs	34
Offer Medicaid coverage of buprenorphine in physicians’ offices	38
Offer Medicaid coverage of buprenorphine in NTPs	30
Offer Medicaid coverage of naltrexone in physicians’ offices	31
Offer Medicaid coverage of naltrexone in NTPs	19

More AvisaGroup Survey Findings

- SAPT Block Grant funds rarely used to cover medication-assisted opioid treatment, except in some cases where states supplement MAT funding
- in NTP's

Coverage	Number States
SAPT Block Grant Funding for buprenorphine in physicians' offices	2
SAPT Block Grant Funding for buprenorphine in NTPs	12
SAPT Block Grant Funding for naltrexone in physicians' offices	2
SAPT Block Grant Funding for naltrexone in NTPs	7

A New Jersey Study Example

Commentary from a New Jersey Study (2005):

- "…a strong correlation [was found] between having a prescription drug benefit or a family member paying for medication and retention in the program; ability to pay for treatment is certainly one factor limiting treatment success." (Colemeco, S. et al., JAD, 2005)

- " For patients without health insurance, monthly treatment costs range from $300 to $500 per month…those patients who had health insurance or financial support from family were much more likely to stay in treatment than those who did not." (ibid)

A New Jersey Study Example

- “Medicaid patients were not included in the study, because NJ Medicaid will not pay family physicians for office-based treatment; addiction treatment is “carved out” of Medicaid managed care plan contracts. (ibid)
- Although insurance companies choose to include buprenorphine on formularies, none pay physicians for office-based treatment as a separately billable service. Patients routinely pay cash for this “non-covered” benefit.” (ibid.)

Conclusions

- We need to better understand whether and how the specialty of the prescriber influences the nature of the treatment received,e.g., whether patients receive psychosocial services that are indicated.
- Much more needs to be learned, under health care reform, about how medications will be financed---what combination of BG and Medicaid funds will provide the best access to medications for patients.

Conclusions (con't)

- Healthcare reform includes Accountable Care Organizations: more work needs to be done to implement the NQF Standards of Care that can be used to create accountable care that includes medications.

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